

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5065

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

302 05014

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELLEN</b> Last <b>ALDER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9 1893</b>
9. AGE (In years lost birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael Kreps</b>		14. MOTHER'S MAIDEN NAME <b>Rosella Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>	
17. INFORMANT <b>James R. Alder</b>		Address <b>435 No Colonial Dr</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> 420.1 DUE TO <b>Primary Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4 1/2 yrs</b> (c) <b>2 weeks</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4-24</b> to <b>4-8</b> , 19 <b>60</b> that (I) <del>(was)</del> last saw the deceased alive on <b>4-8</b> , 19 <b>60</b> , and that death occurred <b>7:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dalton M. Welty</b>		22b. DATE SIGNED <b>4-9-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DALTON M. WELTY</b>		22d. ADDRESS <b>998 Potomac Ave, Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>4/11/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>APR 12 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>	



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5066

Item 8 Film 6201 4/15/60 iwk

CERTIFICATE OF DEATH

05015

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN 1b <b>32 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>17 South Foundry Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Kearfott Baker Ardinger</b>		4. DATE OF DEATH Month Day Year <b>April 9 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 28 1888</b>
9. AGE (In years last birthday) <b>71</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior Decorator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Charles Andrew Ardinger</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Virginia Lemen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-9010</b>	
17. INFORMANT <b>Mrs. Florence Ardinger</b>		17. ADDRESS <b>17 S. Foundry St. Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Emphysema - lungs</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 23 1960</b> to <b>April 9 1960</b> , that (I) (we) last saw the deceased alive on <b>Oct 23 1960</b> , and that death occurred at <b>6:15</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Philip J. Hirshman</b>		22b. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		22d. ADDRESS <b>159 W. Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>April 12-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Alberta Lesf Williamsport, Md</b>		25a. REC'D BY REGISTRAR <b>DATE APR 12 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Carlton S. Kunk</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

05016

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 3</b>				c. LENGTH OF STAY IN 1b <b>55 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Alternate R # 40</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>BREWER</b> Last <b>ARTZ</b>				4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jany 8 1905</b>	
9. AGE (In years lost birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.		IF UNDER 24 HRS. Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frank M. Brewer</b>				14. MOTHER'S MAIDEN NAME <b>Minnie O. Stouffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Howard M. Artz</b>				Address <b>Hagerstown Md. R # 3</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO <b>Obesity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Vascular Disease</b> (c) <b>10 yrs</b> <b>5 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Alternate R # 40</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>11-10-1960</b> to <b>4-6-1960</b> , that (I) (we) last saw the deceased alive on <b>2-1-60</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>A. J. De Otto Jr</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Dr E W De Otto Jr</b>				22d. ADDRESS <b>Hagerstown Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4/9/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b> ADDRESS <b>Hagerstown Md.</b>				25a. REC'D BY REGISTRAR <b>APR 11 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kram</b>	

TESTIMONY OF DEATH

2017

I, the undersigned, being a competent witness to the death of \_\_\_\_\_ do hereby certify that \_\_\_\_\_ died on \_\_\_\_\_ at \_\_\_\_\_ in the County of \_\_\_\_\_ State of \_\_\_\_\_ at the age of \_\_\_\_\_ years.

Witness my hand and seal this \_\_\_\_\_ day of \_\_\_\_\_ 2017.

\_\_\_\_\_  
Notary Public for the State of \_\_\_\_\_



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5032

65017  
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPSBURG</u> c. LENGTH OF STAY IN 1b <u>03</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ALONG ROUTE 34</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN MD.</u> d. STREET ADDRESS <u>650 NORTH PROSPECT ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES WILLIAM AUTHERS JR.</u> First Middle Last		4. DATE OF DEATH <u>APRIL - 17 1960</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 11 - 1935</u>
9. AGE (In years last birthday) <u>24</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u>	11. IF UNDER 24 HRS. Hours <u>4</u> Min. <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRAFTSMAN - JANISON COLO STORAGE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WASH. CO. MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES WILLIAM AUTHERS SR.</u>		14. MOTHER'S MAIDEN NAME <u>GOLDIE PALMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>214-34-0559</u>	
17. INFORMANT <u>MRS. PATSY AUTHERS</u>		Address <u>650 N. PROSPECT ST HAGERSTOWN MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Compound Comminuted Fracture Lt. Femur &amp; Tibia</u> DUE TO (c) <u>Compound Fracture Of Left Humerus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speeding car left road crashing into tree.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:17</u> p. m. <u>4-17-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R # 34</u>		20f. (City or town) (County) (State) <u>Sharpsburg, Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-19-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 21 - 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Darr</u>		ADDRESS <u>BOONSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

1917

NAME OF DECEASED *WILLIAM A. WILSON*

RESIDENCE *100 W. 10th St. Boston*

AGE *65* SEX *M*

DATE OF DEATH *Nov 10 1917*

PLACE OF DEATH *Home*

Cause of Death *Myocardial Infarction*

Immediate Cause *Coronary Atherosclerosis*

Contributing Cause *Hypertension*

Occupation *Engineer*

Signature of Examiner *W. A. Wilson*

Signature of Physician *W. A. Wilson*

Signature of Coroner *W. A. Wilson*

Signature of Registrar *W. A. Wilson*

Signature of Medical Officer *W. A. Wilson*



5067

CERTIFICATE OF DEATH

05019  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>40 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>25 WEST SIDE AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PAUL</b> Middle <b>HARRY</b> Last <b>BARNHART</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/4/1897</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>	11. IF UNDER 24 HRS. Months <b>62</b> Days <b>62</b> Hours <b>62</b> Min. <b>62</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER CO.</b>	11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>HARRY BARNHART</b>	
14. MOTHER'S MAIDEN NAME <b>ADA HESSER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>214-09-1111</b>		17. INFORMANT <b>MRS. AUDREY BARNHART</b> Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymph sarcoma</b> <b>200.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>200.1</b> DUE TO (c) <b>200.1</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1 Jan</b> , 19 <b>57</b> , to <b>5 April</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4 April</b> , 19 <b>60</b> , and that death occurred at <b>225 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 W. West St. Hagerstown Md.</b> DATE SIGNED <b>4/12/60</b>			
ACTUAL SIGNATURE <b>E. John D. Howland</b> M.D.		PHYSICIAN'S NAME (Type) <b>E. John D. Howland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/8/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norman</b>		24a. REC'D BY REGISTRAR <b>APR 11 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5099

0520  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution—Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>near Sharpsburg, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Waynesboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>near Sharpsburg, Md.</u>		d. STREET ADDRESS <u>Route 3 - Waynesboro</u>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Lewis</u> Middle <u>Bingaman, Jr.</u> Last		4. DATE OF DEATH <u>4/17</u> Month <u>4</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>12/30/1930</u>	9. AGE (In years last birthday) <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lubricator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (State or foreign country) <u>Waynesboro, Pa.</u>
13. FATHER'S NAME <u>John L. Bingaman</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Rowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 1945-8/5/54</u>		16. SOCIAL SECURITY NO. <u>186-24-7587</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO <u>Fracture Cervical Vertebrae</u> Conditions, if any, which gave rise to immediate cause (b) <u>Compound Fracture Both Femur</u> (a), stating the underlying cause last. DUE TO (c) <u>Entire face Crushed</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speeding car left road crashing into tree.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>7:41</u> p. m. <u>4-17</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State Rt 34 Sharpsburg Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. E. W. D. T. To 9</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A. E. W. D. T. To 9</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Broadfording Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Wash. Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. W. D. T. To 9</u>		24a. REC'D BY REGISTRAR <u>APR 21 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hantz</u>



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05021

5100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown rural 3</b>				c. LENGTH OF STAY IN 1b <b>40 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Route 3</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles William Black</b>				4. DATE OF DEATH Month Day Year <b>4 12 1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-21-1895</b>	
9. AGE (In years last birthday) <b>65 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>warehouseman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>P. R. R.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Luther S. Black</b>				14. MOTHER'S MAIDEN NAME <b>Euphemia Blose</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>717-07-9361</b>		17. INFORMANT <b>Mrs. Charlotte Black Hagerstown, Md. R3</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				Carcinoma Bladder INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown, Md.</b>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10-1-58</b> to <b>4-12-60</b> , that (I) (we) last saw the deceased alive on <b>3-4-60</b> , and that death occurred at <b>1 A.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>F. W. Kraiss</b>				22b. DATE SIGNED <b>APR 18 '60</b>			
22c. PHYSICIAN'S NAME (Type) <b>DREW HITTAGE</b>				22d. ADDRESS <b>Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4-14-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				25. REC'D BY REGISTRAR <b>Hagerstown, Md.</b>			
25a. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>							

1810



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5068

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

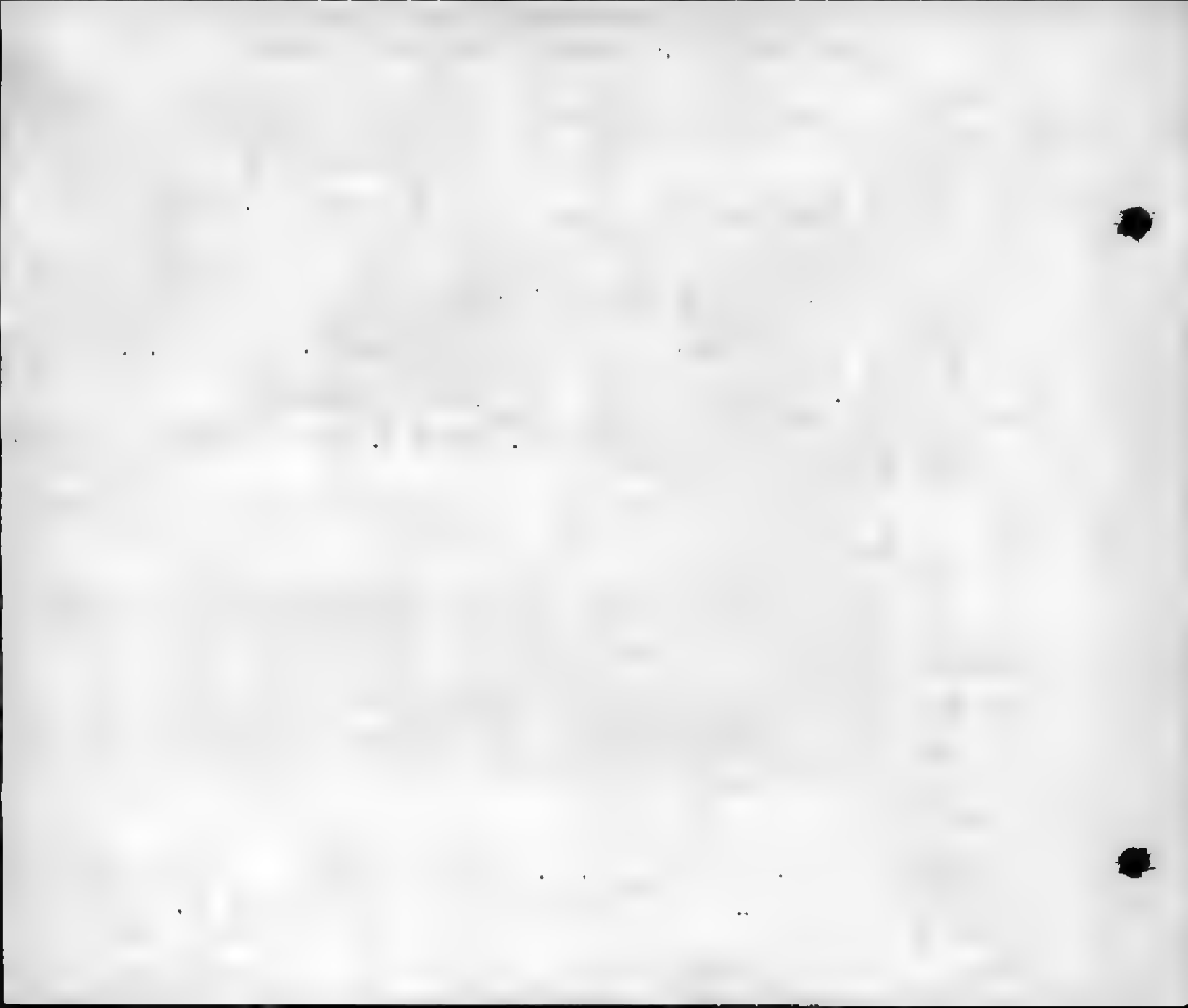
05022

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>				e. IS RESIDENCE OF A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Duckett</b> Last <b>Bloom</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 29 1873</b>	
9. AGE (In years less birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>21</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tenant Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Tilghmanton Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>John L. Bloom</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Ann Harigan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>217 18 1849</b>			
17. INFORMANT <b>Mr. Milton R. Bloom</b>				Address <b>Hagerstown Md RFD #3</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Advanced coronary atherosclerosis</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO <b>unusual</b> (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>under anesthesia for below knee amputation for gangrene of foot</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 23-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bakersville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Williamsport 2 Maryland</b>				24. REC'D BY REGISTRAR <b>APR 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

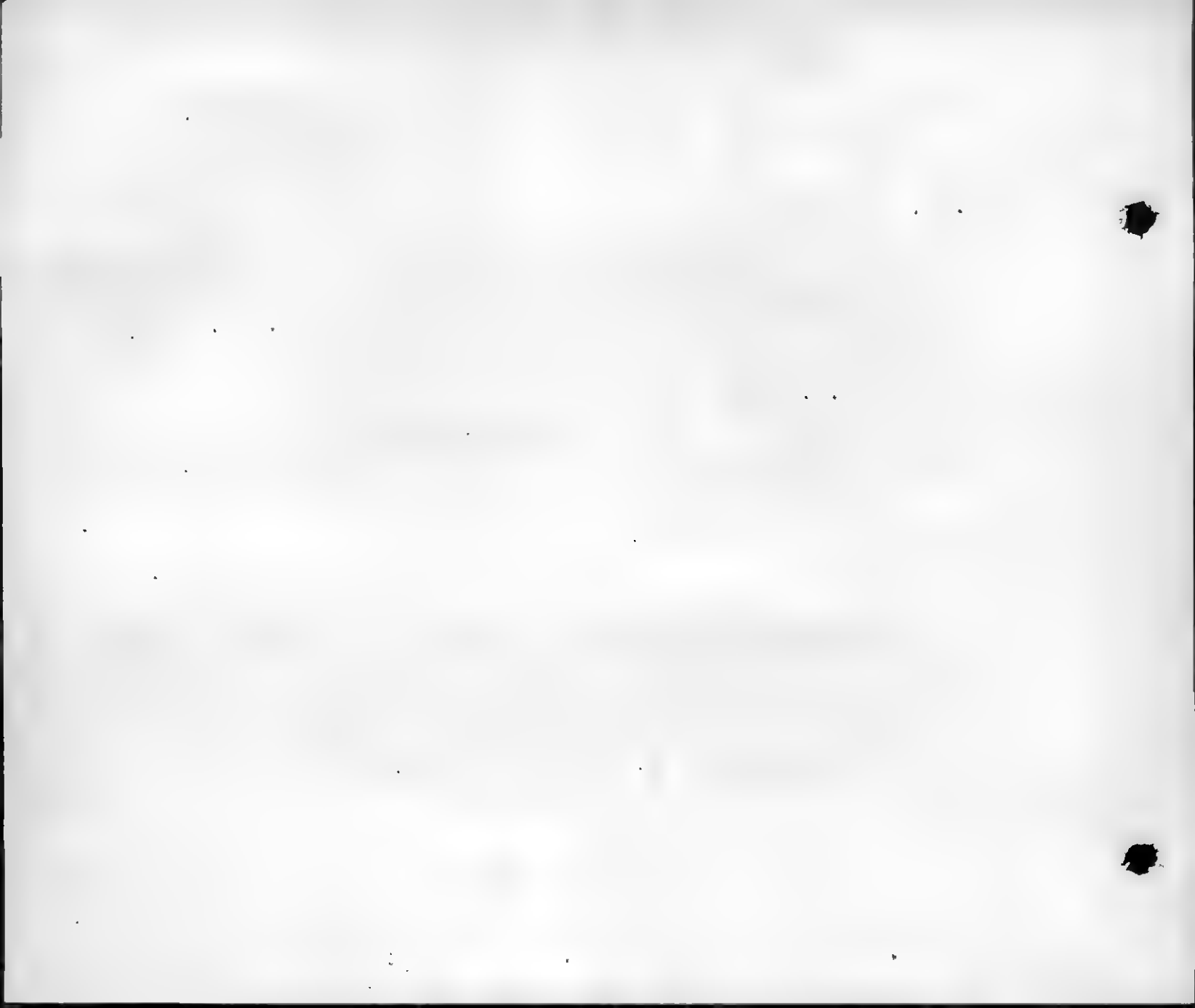


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05023  
302

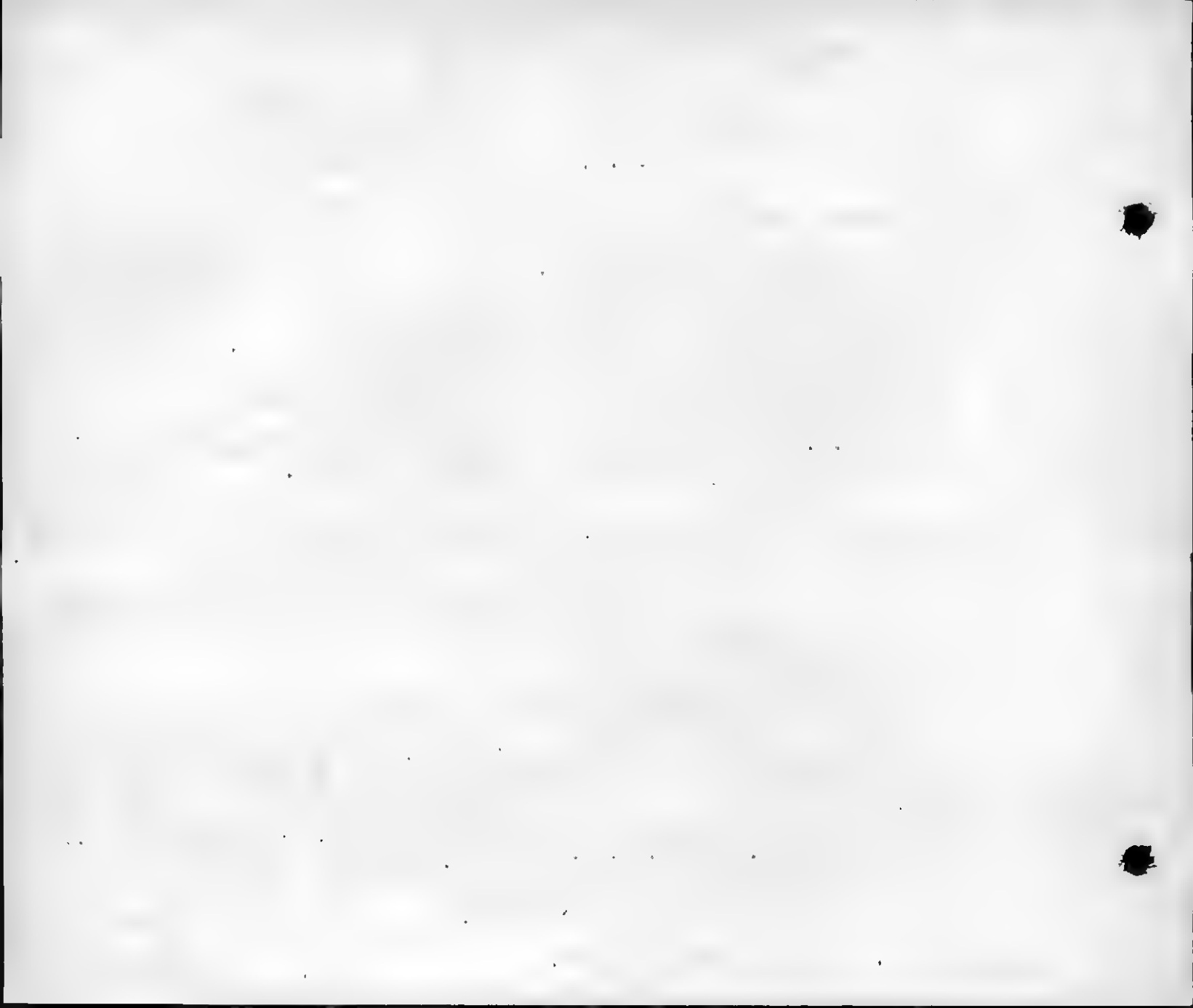
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 Mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>W. Md. State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
f. STREET ADDRESS <b>341 South St</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Bell</b> Last <b>Bowers</b>				4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 17 1889</b>	
9. AGE (in years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Martin V.B. Green</b>			
14. MOTHER'S MAIDEN NAME <b>Susan Smith</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO <b>None</b>				17. INFORMANT <b>Mrs Virginia Corsi</b> Address <b>401 So Potomac st</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>lobular pneumonia, bilateral</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>cerebral thrombosis</b> DUE TO (c) <b>general arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 days</b> <b>4 mos</b> <b>unknown</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <input type="checkbox"/> p. m. <input type="checkbox"/>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown Md.</b>				(County) <b>Washington</b>		(State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 4, 1960</b> to <b>April 2, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1960</b> , and that death occurred at <b>6:57 AM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Victor L. Ramos, M.D.</b>				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>April 2, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>Victor L. Ramos</b>				22d. ADDRESS <b>Western Md. State Hospital, Hagerstown Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 5 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. House</b>				25c. DATE <b>APR 5 '60</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5070  
05024  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1049 Columbia Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ALVIE</b> Middle <b>LEROY</b> Last <b>BROWN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 12 1899</b>	
9. AGE (In years last birthday) <b>61</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (State or foreign country) <b>Thurmont Fred Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Builder</b>		11. BIRTHPLACE (State or foreign country) <b>Thurmont Fred Co Md.</b>	
13. FATHER'S NAME <b>Reuben Brown</b>				14. MOTHER'S MAIDEN NAME <b>Miranda May Harbaugh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes W.W.# 2</b>				16. SOCIAL SECURITY NO. <b>291-01-8327</b>			
17. INFORMANT <b>Mrs Madeline Brown</b>				Address <b>1049 Columbia Rd</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> No history of.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>April 3, 1960</b> to <b>April 3, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1960</b> , and that death occurred at <b>2</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>W. T. Layman</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>William T. Layman, M. D.,</b>				22d. ADDRESS <b>100 Professional Arts Bldg., Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/5/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md/</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		25a. REC'D BY REGISTRAR <b>APR 7 '60</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	





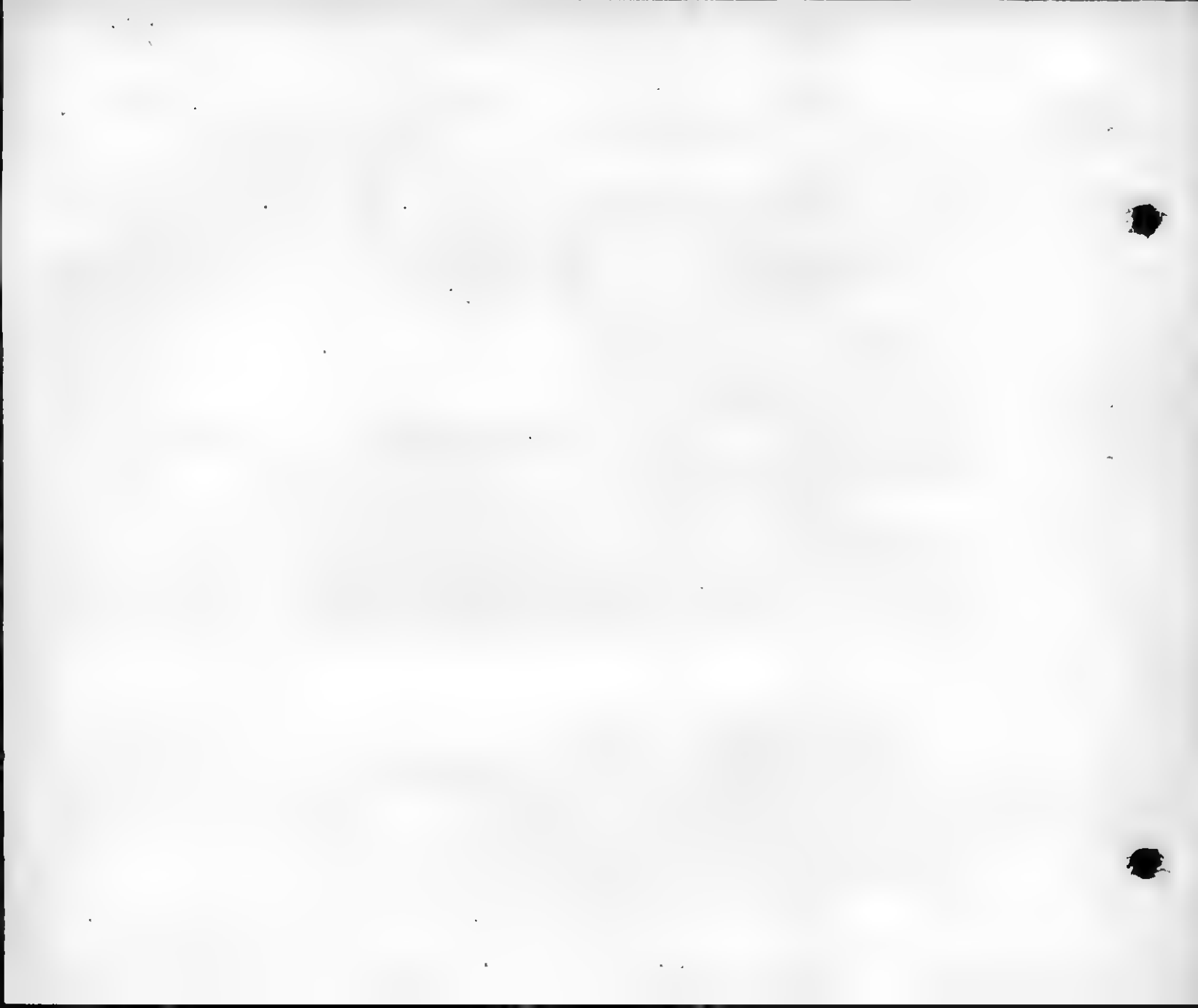
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5071**  
**CERTIFICATE OF DEATH**

05025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>Life</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				f. STREET ADDRESS <b>225 W. Franklin St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ALLEN</b> Middle <b>EUGENE</b> Last <b>CARPENTER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>19</b> Year <b>1960</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 17, 1958</b>	9. AGE (in years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elwood Carpenter</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Best</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Hagerstown, Md.</b> <b>Mr. Elwood Carpenter 225 W. Franklin St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atelectasis, bilateral; with</b> DUE TO (b) <b>cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>obstructive hydrocephalus</b>							INTERVAL BETWEEN ONSET AND DEATH <b>72 hr.</b> <b>18 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 17, 1958</b> to <b>Apr. 19, 1960</b> , that I last saw the deceased alive on <b>Apr 19, 1960</b> , and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>217 W. Washington St. Hagerstown, Md.</b> DATE SIGNED <b>4/21/60</b> ACTUAL SIGNATURE <b>Edward W. Dittz M.D.</b> PHYSICIAN'S NAME (Type) <b>Edward W. Dittz M.D. Hagerstown, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
TSM 9/59

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05026  
302

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>8 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1917 Virginia Ave</b>		d. STREET ADDRESS <b>1917 Virginia Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA GERTRUDE CARTER</b>		4. DATE OF DEATH Month Day Year <b>April 13 1960 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 16 1872</b>
9. AGE (In years at birthday) <b>88</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Brownsville Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John L. Mills</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Gordon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Edward Q. Carter</b>		Address <b>122 E. Main St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus; Arteriosclerosis, generalized.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <del>the deceased</del> attended the deceased from <b>March 14, 1958</b> to <b>Apr. 13, 1960</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>April 12, 1960</b> , and that death occurred at <b>10:15 P. M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. T. Layman, M.D.</b>		22b. DATE SIGNED <b>APR 13 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. T. Layman, M.D.</b>		22d. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/16/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>APR 18 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

420.8

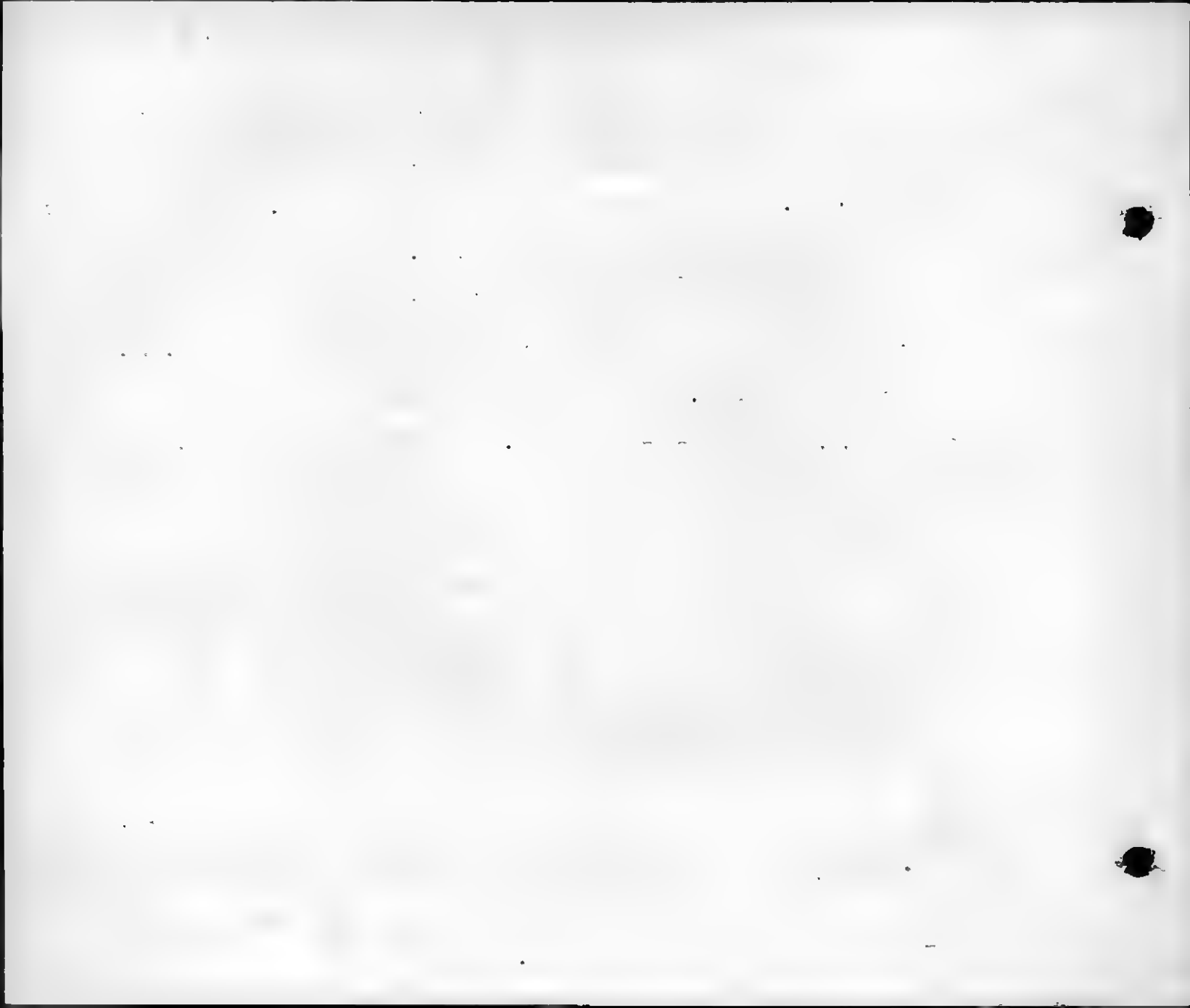
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5073

05027

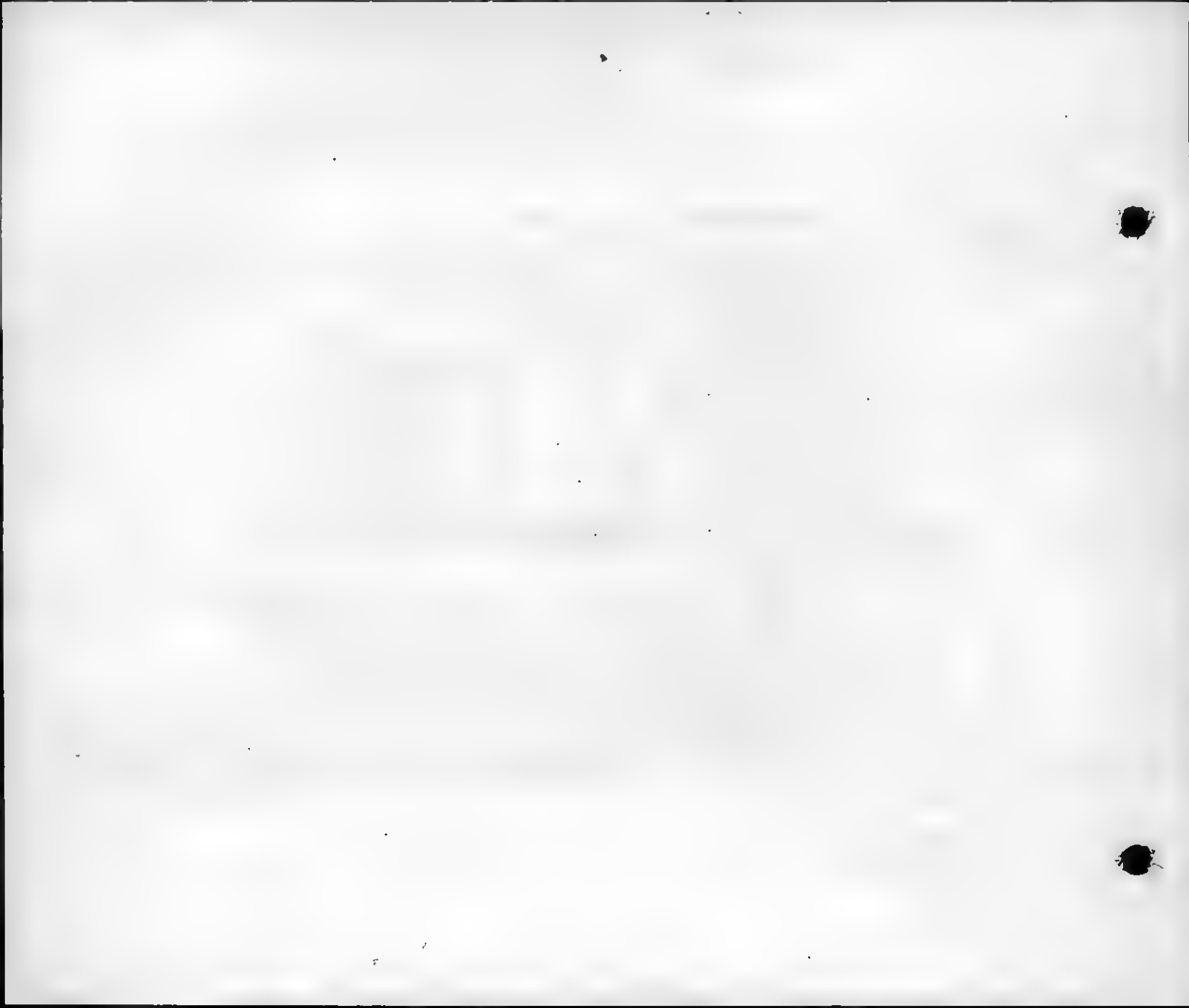
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>8 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>980 Northern Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BRAWNER</b> Middle Last <b>CATES, JR.</b>				4. DATE OF DEATH Month <b>April</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 8, 1923</b>	
9. AGE (In years last birthday) <b>37</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Managers</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>plumbing whosaler</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Brawner Cates, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Ella Merchant</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W.II</b>		17. INFORMANT <b>Mrs. Helen Cates</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Heart Failure</b> <b>416X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dissecting Aortic Aneurysm</b> 3 mo. (c) <b>Rheumatic Heart Disease - old</b> 30 yrs.							INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Vascular Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JAN 29 1960</b> to <b>APRIL 8 1960</b> , that (I) <del>(we)</del> lost the deceased alive on <b>APRIL 8 1960</b> , and that death occurred at <b>2:45 M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Lloyd A. Hoffmann</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4/9/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffmann</b>				22d. ADDRESS <b>214 N. Pot. St. Hagerstown, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/11/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Richmond, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>H. Franklin Rouzer</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>APR 11 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4. This certificate may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.







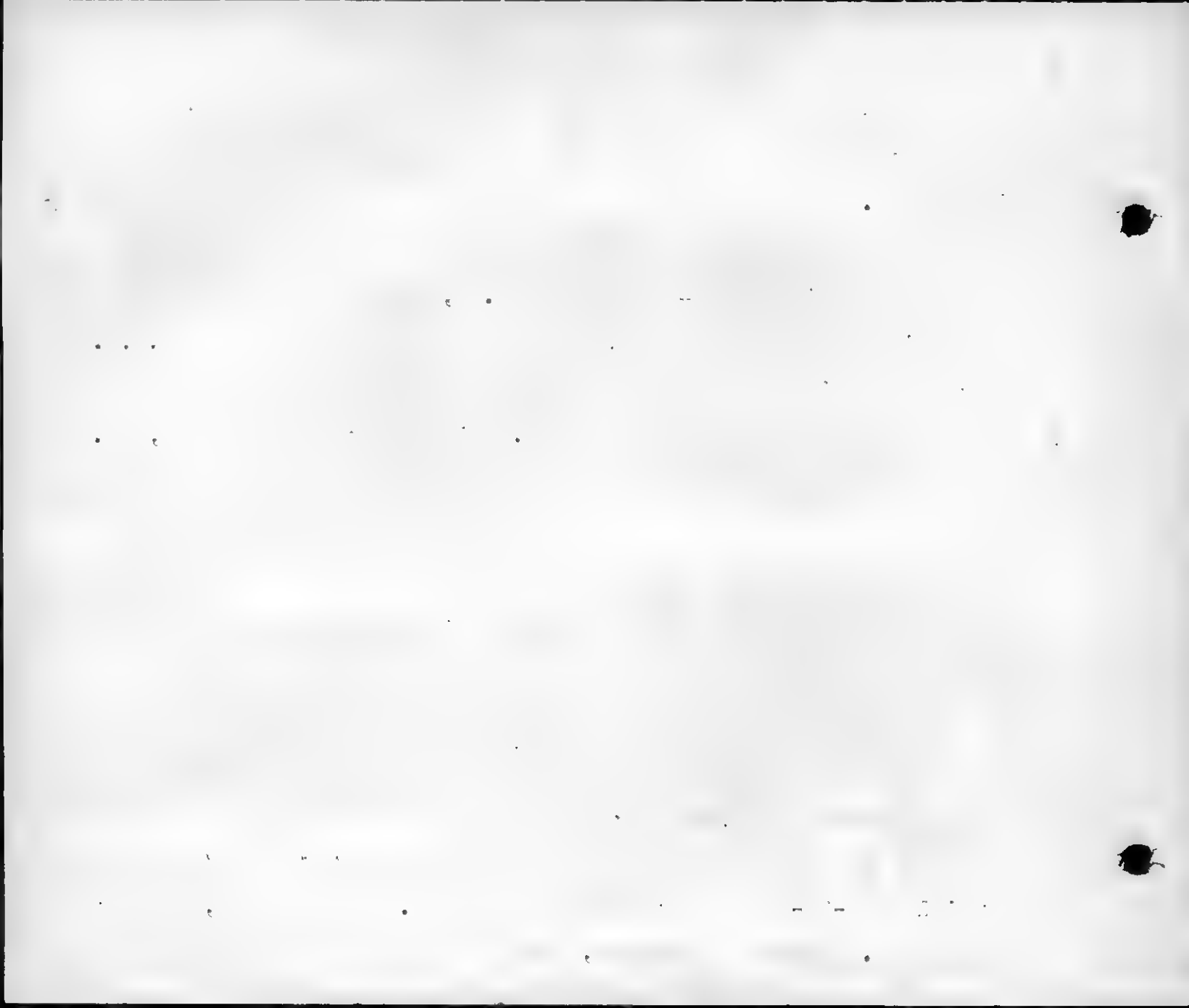


TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5025  
05029  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 191 Western Md. State Hospital		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last Queenie A. Cook		4. DATE OF DEATH Month Day Year April 24, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Jan. 4, 1867
9. AGE (In years lost birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Davis		14. MOTHER'S MAIDEN NAME Susan Wilhide	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Goldie Anders		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobular pneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cardiac decompensation (b) General Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from March 30, 1960, to April 24, 1960, that (I) (we) last saw the deceased alive on April 24, 1960, and that death occurred at 5:30 PM, from the causes and on the date stated above			
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED April 24, 1960	
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos		22d. ADDRESS Western Md. State Hospital, Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-60	
23c. NAME OF CEMETERY OR CREMATORY United Brethren Cem.		23d. LOCATION (City, town, or county) (State) Thurmont, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Maryland	
25a. REC'D BY REGISTRAR APR 27 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



5076

# CERTIFICATE OF DEATH

05030

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>LIFE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>GORDON MEM. CONV. HOME</b>		e. STREET ADDRESS <b>1915 DREW AVE.</b>	
3. NAME OF DECEASED (Type or print) First <b>NETTIE</b> Middle <b>CATHERINE</b> Last <b>CROMER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/11/1880</b>
9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ABRAHAM RHODES</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET FORTHMAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-7570</b>	
17. INFORMANT <b>MRS. CATHERINE BLACKBURN</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease with</b> (c) <b>Myocardial Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 gm</b> <b>10 gm</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1955</b> , 19 <b>60</b> to <b>4 Apr</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4 Apr</b> , 19 <b>60</b> , and that death occurred at <b>2:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, City or town, state) <b>230 N. Thomas</b> DATE SIGNED <b>5 April 60</b> ACTUAL SIGNATURE <b>F. F. Lusby</b> PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b> M.D. <b>Hagerstown</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/6/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. T. Hagerman</b>		24a. REC'D BY REGISTRAR DATE <b>APR 7 '60</b>	
ADDRESS <b>Hagerstown, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	





Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Hagerstown #5</b>		c. LENGTH OF STAY IN 1b <b>21 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Smithsburg #2, near Hagerstown</b>		d. STREET ADDRESS <b>Smithsburg #2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown #5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Etta</b>		First <b>L.</b>		Middle <b>Davis</b>		Last	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH <b>April 15, 1960</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Lantz Md.</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		12. DATE OF BIRTH <b>Aug. 24, 1877</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>Samuel Pryor</b>		14. MOTHER'S MAIDEN NAME <b>Louise Kline</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. G. Calvin Shoop, Hagerstown Md., #5</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Congestive failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes mellitus</b> DUE TO <b>Insulin administration</b> (c) <b>Small cell carcinoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b> <b>5 1/2 wks</b> <b>5 yrs</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1950</b> to <b>April 15, 1960</b> , that I last saw the deceased alive on <b>April 13, 1960</b> , and that death occurred at <b>Md.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Dr. David R. Hess</b>		DATE SIGNED <b>April 18, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/17/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harbaugh's</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg #5, Franklin Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Hess</b>		ADDRESS <b>1114 1/2 W. 2nd St. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hess</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20

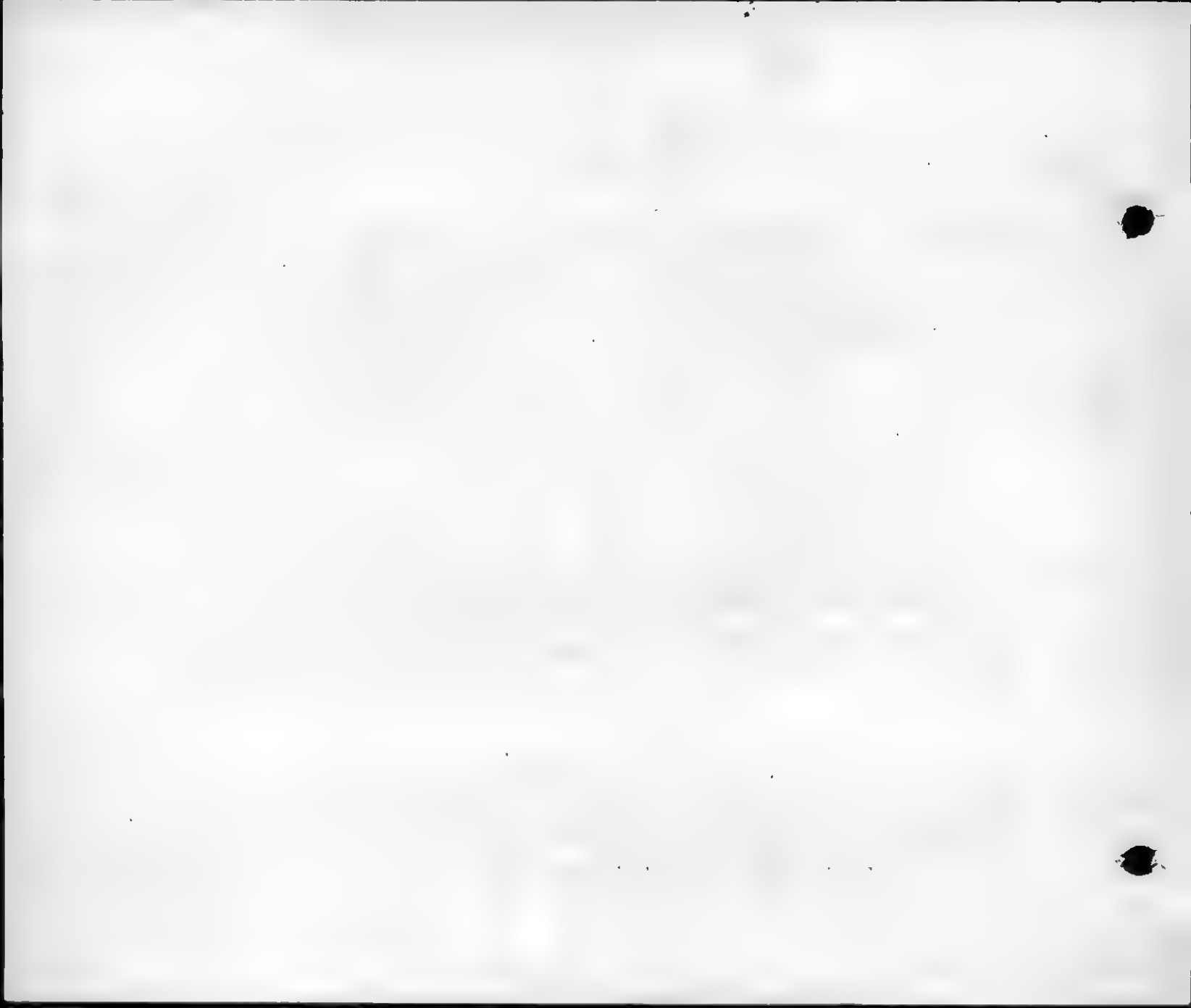
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 2 may be used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5077

05032

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>3 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. STREET ADDRESS <u>NO. 6 S. CANNON AVE</u>			
3. NAME OF DECEASED (Type or print) <u>ADAM SAMUEL DIETERICH</u>				4. DATE OF DEATH <u>APRIL 29</u> 19 <u>60</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 24 - 1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PANGBORN CORP.</u>		11. BIRTHPLACE (State or foreign country) <u>WASH. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>SAMUEL DIETERICH</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA VANDREAU</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>U.S. NAVY</u>	
16. SOCIAL SECURITY NO. <u>217-15-7872</u>		17. INFORMANT <u>MRS. MABLE DIETERICH</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis and vascular hypertension</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u> <u>Undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (1) (this hospital) attended the deceased from <u>Jan. 11 1958</u> to <u>April 29, 1960</u> , that (1) (we) last saw the deceased alive on <u>April 29, 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above							
22a. SIGNATURE <u>B. B. Kneisley</u>				22b. DATE SIGNED <u>May 2, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 13, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PANGBORN CEMETERY</u>		23d. LOCATION (City, town, or county) <u>PANGBORN WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Burt</u>				25a. REC'D BY REGISTRAR <u>May 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



5078

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>Washington</b> <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	c. LENGTH OF STAY IN 1b <b>35 Yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown, R.F.D.#1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. James Washington County Hospital</b>		d. STREET ADDRESS <b>307 Robinwood Drive.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Karl</b> Last <b>Dinkel</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N. American Cement</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George M. Denkel</b>	
14. MOTHER'S MAIDEN NAME <b>Louise Krauss</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>213-10-6826</b>		INFORMANT <b>Catherine Dinkel Hagerstown, R.D. 1 Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary artery occlusion</b> DUE TO <b>Coronary atherosclerosis</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO <b>Coronary atherosclerosis</b> (c) <b>Coronary atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 11, 1960</b> to <b>April 11, 1960</b> , that I last saw the deceased alive on <b>April 11, 1960</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>145 W. Washington, St. Hagerstown, Md.</b> DATE SIGNED <b>4/12/60</b>			
ACTUAL SIGNATURE <b>Lawrence L. Packer Jr.</b>		PHYSICIAN'S NAME (Type) <b>Lawrence L. Packer Jr.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/14/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Washing Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Clarence L. Krauss</b>			

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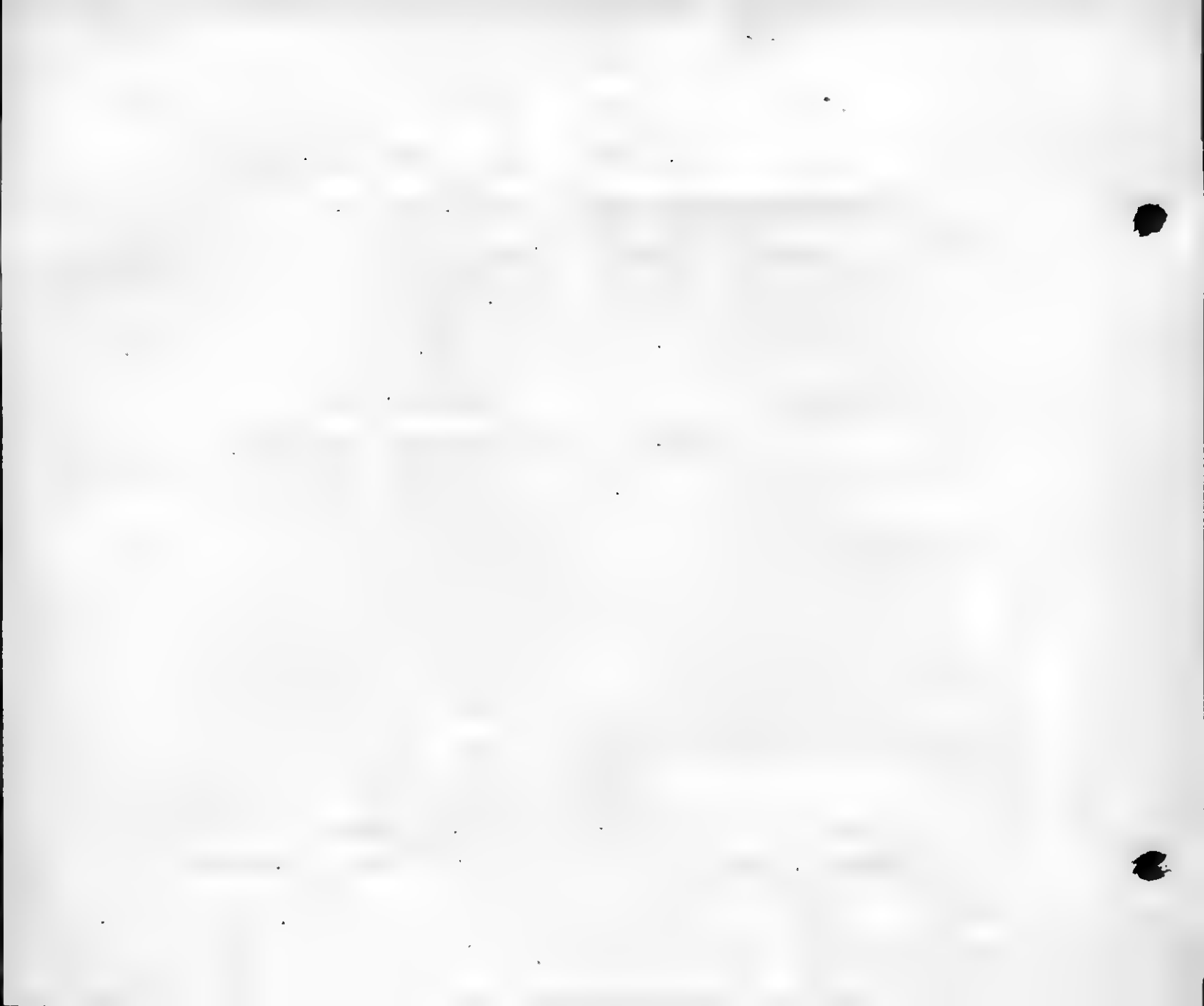
after death.

Page 4

after death.

Page 4

after death.



5079

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> c. LENGTH OF STAY IN 1b <b>40 YRS.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b> d. STREET ADDRESS <b>1201 W. WASHINGTON ST.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CARRIL</b> Middle <b>BLANCHE</b> Last <b>DOFFLEMYER</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>PENDLETON KIBLER</b>	
14. MOTHER'S MAIDEN NAME <b>DOROTHY ANNE STICKLER BURG</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO <b>NONL</b>		17. INFORMANT <b>MRS. GENEVIEVE BAADT</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>200x</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Introspective Heart Disease</b> (c) <b>Diabetes mellitus</b> <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>18 yrs</b> <b>6 yrs</b> <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct 1947</b> to <b>April 11, 1960</b> , that I last saw the deceased alive on <b>April 2, 1960</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. 159 W. Washington St., Hagerstown, Md.</b> DATE SIGNED <b>4/14/60</b>			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/14/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSL HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horvath, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>Apr 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

200X



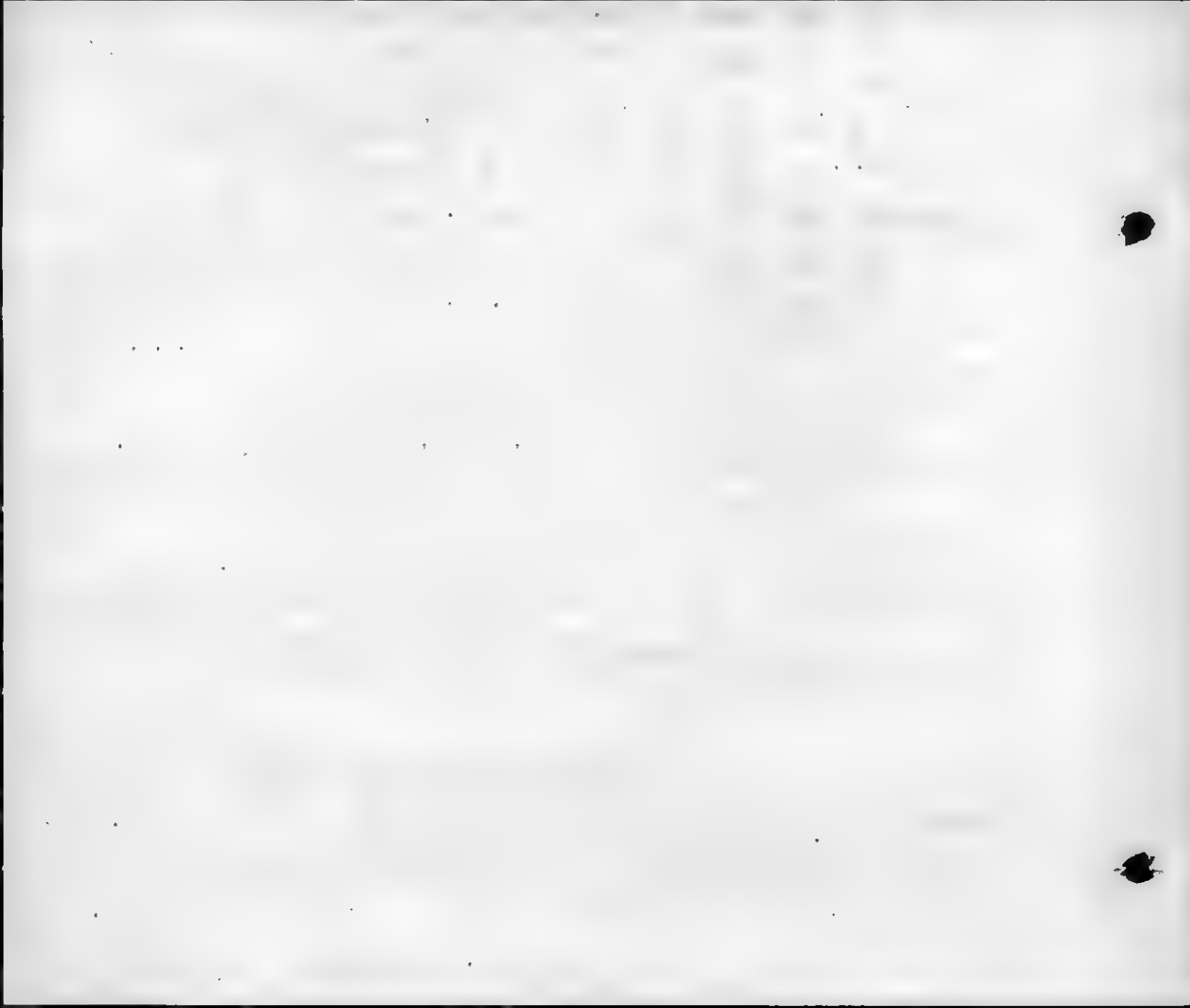
## 5102 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Washington</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <u>Penna.</u> b. COUNTY <u>Cumberland</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R.D. 5</u>		c. LENGTH OF STAY IN 1b <u>6 weeks</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brook Lane Farm</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle _____ Last <u>Doner</u>		4. DATE OF DEATH Month <u>4</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York State</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Herr</u>		14 MOTHER'S MAIDEN NAME <u>Eliza Eshelman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. _____	
17 INFORMANT <u>Mrs. Mark L. Winger</u>		Address <u>Shiremanstown, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arrhythmia and Ventricular Fibrillation</u> DUE TO <u>Cardiac Decompensation</u> DUE TO <u>Hypertensive Cardio Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3/1/58</u> 19 <u>58</u> , to <u>4/25/60</u> 19 <u>60</u> , that I last saw the deceased alive on <u>4/25/60</u> 19 <u>60</u> , and that death occurred at <u>4:15</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>John C. White</u> M.D. <u>Brook Lane Farm Hagerstown R.D. 5 Md.</u> PHYSICIAN'S NAME (Type) <u>Edward W. O'Dell III, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mechanicsburg Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Mechanicsburg</u>		(State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mark L. Winger</u>		ADDRESS <u>Mechanicsburg, Pa.</u>	24a. REC'D BY REGISTRAR DATE <u>Apr 27 '60</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5103 **CERTIFICATE OF DEATH** Item B File # 261 4-20-60 et

302 050 36

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 6</b> c. LENGTH OF STAY IN 1b <b>3Yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Lappans Cross Roads</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 6</b> d. STREET ADDRESS <b>Lappans Cross Roads</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>PEARL</b> Last <b>DORSEY</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1920</b> <b>March 14 1960</b>
9. AGE (in years lost birthday) <b>40</b> yrs		10. IF UNDER 1 YEAR: Months <b>40</b> Days <b>19</b> Hours <b>19</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. BIRTHPLACE (State or foreign country) <b>Princeton Mercer Co Pa</b>	
14. FATHER'S NAME <b>William H. Kessinger</b>		15. MOTHER'S MAIDEN NAME <b>Susie Grubb</b>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. SOCIAL SECURITY NO. <b>-----</b>	
18. INFORMANT <b>Harry P. Dorsey</b>		Address <b>116 No Jonathan St</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy</b> (b) <b>15 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1 1950</b> to <b>4-14 1960</b> that (I) (we) last saw the deceased alive on <b>4-14 1960</b> , and that death occurred on <b>2<sup>nd</sup> P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert P. Conrad</b>		22b. DATE SIGNED <b>4-15-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>		22d. ADDRESS <b>137 W. Wash. Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/16/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Uoffman</b>		25a. REC'D BY REGISTRAR <b>DATE APR 18 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

331X

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05037

5088

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>1 week</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				1. d. STREET ADDRESS <b>339 Ridge Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mamie</b> Middle <b>E</b> Last <b>Dye</b>				4. DATE OF DEATH Month <b>4</b> Day <b>24</b> Year <b>19 60</b>			
5 SEX <b>female</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 12, 1903</b>		9. AGE (In years lost birthday) <b>57 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter Lang</b>				14. MOTHER'S MAIDEN NAME <b>Nettie Deavers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Miss Brenda L. Dye Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Metastatic CA OF BRAIN</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adeno-ca OF UTERUS</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo.</b> <b>6 Mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Feb. 2, 1960</b> to <b>April 24, 1960</b> , that (I) <del>met</del> last saw the deceased alive on <b>April 24, 1960</b> , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE <b>John A. Moran M.D.</b>				22b. ADDRESS <b>215 W. WASHINGTON ST., HAGERSTOWN</b>		22c. PHYSICIAN'S NAME (Type) <b>JOHN A. MORAN M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4-27-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				25a. REC'D BY REGISTRAR DATE <b>APR 26 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Krauss</b>	



5104  
CERTIFICATE OF DEATH05088  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown Rt. 5</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>	
3. NAME OF <del>DECEASED</del> <b>Perry</b> First Middle Last <b>Forcino</b>		4. DATE OF DEATH <b>April 14 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 7, 1905</b>
9. AGE (In years last birthday) <b>55</b> yrs		10. IF UNDER 1 YEAR <b>55</b> Manths Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement mixer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cement mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Giosia Forcino</b>		14. MOTHER'S MAIDEN NAME <b>Elevia Schiazzo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. W. 11 213-10-6774</b>	
17. INFORMANT <b>Mrs. Margaret C. Forcino</b>		Address <b>Rt. 5</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis</b> <b>+201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>30 years</b> <b>Years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 June 1957</b> to <b>14 April 1960</b> , that I last saw the deceased alive on <b>4 April 1960</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eldon G. Hoachlander</b>		ADDRESS (Street, city or town, state) <b>115 W. Washington St.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Eldon G. Hoachlander</b>		<b>Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-18-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5081

302

05039

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b>			
c. LENGTH OF STAY IN 1b <b>3 Yrs</b>				d. STREET ADDRESS <b>Antietam St</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Martin Manor Nursing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>RUTH NUNAMAKER FOREMAN</b>				4. DATE OF DEATH <b>April 6 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 23 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Eavey Nunamaker</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Careyle M. Foreman</b> Address <b>453 W. Antietam St</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cardiovascular collapse</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>myocardial failure</b> DUE TO <b>arteriosclerosis</b> (c) <b>arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none except stroke 12 m. ago</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 1954</b> to <b>Apr 6 1960</b> , that (I) (we) last saw the deceased alive on <b>April 5 1960</b> , and that death occurred on <b>April 6 1960</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Louis G. Graff</b>				22b. DATE SIGNED <b>4-8-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Louis G. Graff M.D.</b>				22d. ADDRESS <b>119 E. Antietam St. Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>rose hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				25a. REC'D BY REGISTRAR <b>APR 11 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

MEDICAL CERTIFICATION



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

050411  
 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Hr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maugansville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Greencastle Pike</b>				d. STREET ADDRESS <b>North Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES SELVA FOSTER Sr</b>				4. DATE OF DEATH Month Day Year <b>April 12 1960 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4 1899</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Corp</b>		11. BIRTHPLACE (State or foreign country) <b>PA</b> <b>Enid Fulton Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thornton Foster</b>				14. MOTHER'S MAIDEN NAME <b>Susan Truax</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>161-12-7620</b>		17. INFORMANT Address <b>Charles S. Foster Jr Hagerstown R # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 yrs</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Greencastle Pike</b> INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Andrew K. Coffman</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Andrew K. Coffman</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wells Valley U.B. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Pa</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>APR 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

THIS MEDICAL EXAMINER'S CERTIFICATE OF DEATH should be completed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

420.0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

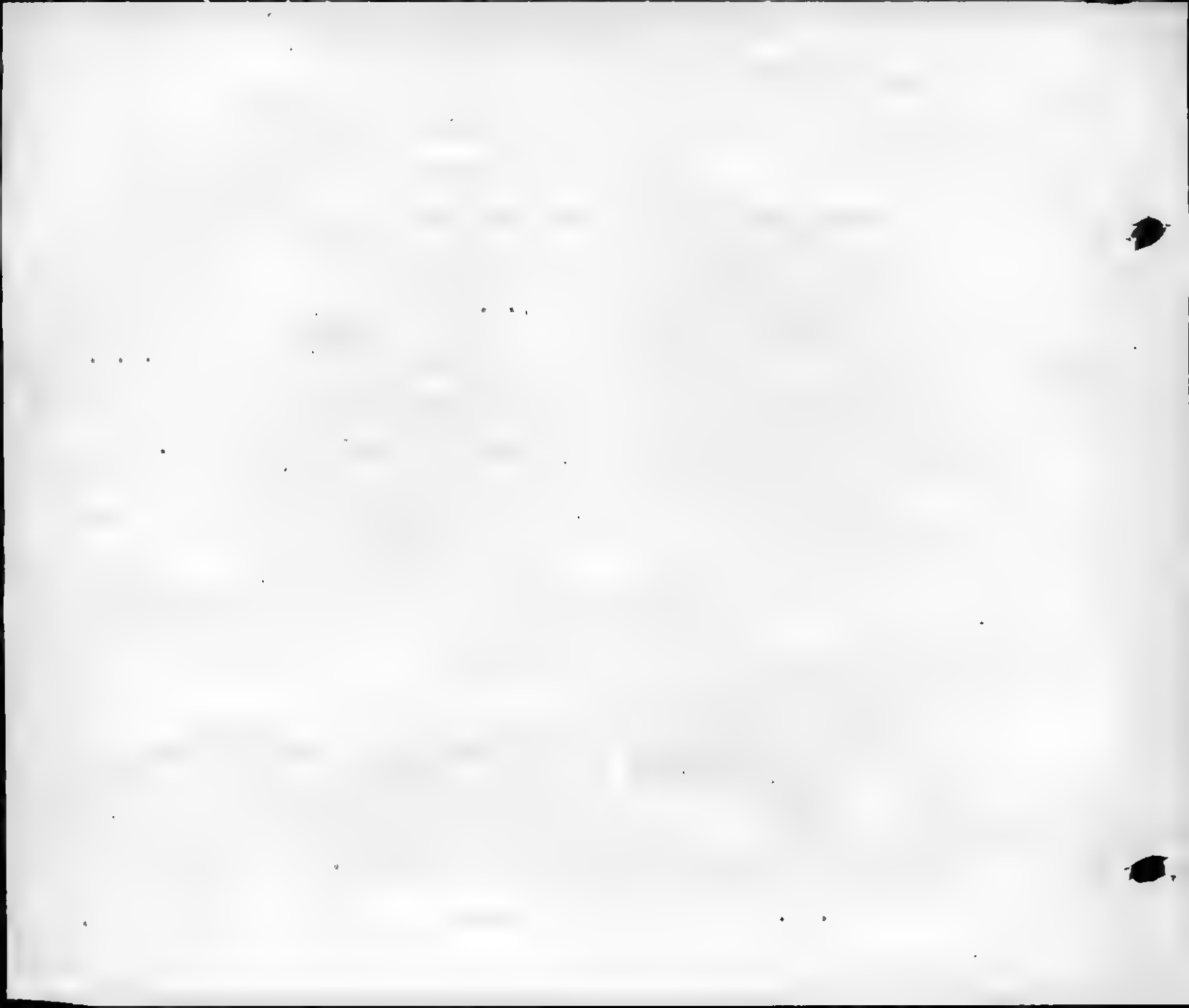
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05041

5105

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock Md</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Graves</b> Last <b>Francis</b>		4. DATE OF DEATH Month <b>4</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>W F</b>	6. COLOR OR RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>7.2.1883</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR: Months <b>9</b> Days <b>21</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wesley Brumback</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Long</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Thomas A Francis Hancock Md.</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>Arterio Sclerotic</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Coronary disease</b> (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>3mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b> (County) <b></b> (State) <b></b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Apr 22 1960</b> to <b>Apr 23 1960</b> that (I) <b>last</b> saw the deceased alive on <b>Apr 22 1960</b> and that death occurred at <b>11 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>L. M. Shaffer</b>		22b. DATE SIGNED <b>4/27/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. M. SHAFER - HANCOCK</b>		22d. ADDRESS <b>Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4.27.60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		23d. LOCATION (City, town, or county) <b>Hancock Washington Md.</b> (State) <b></b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hancock &amp; Stone Hancock Md</b>		25a. REC'D BY REGISTRAR <b>APR 29 '60</b> DATE <b></b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

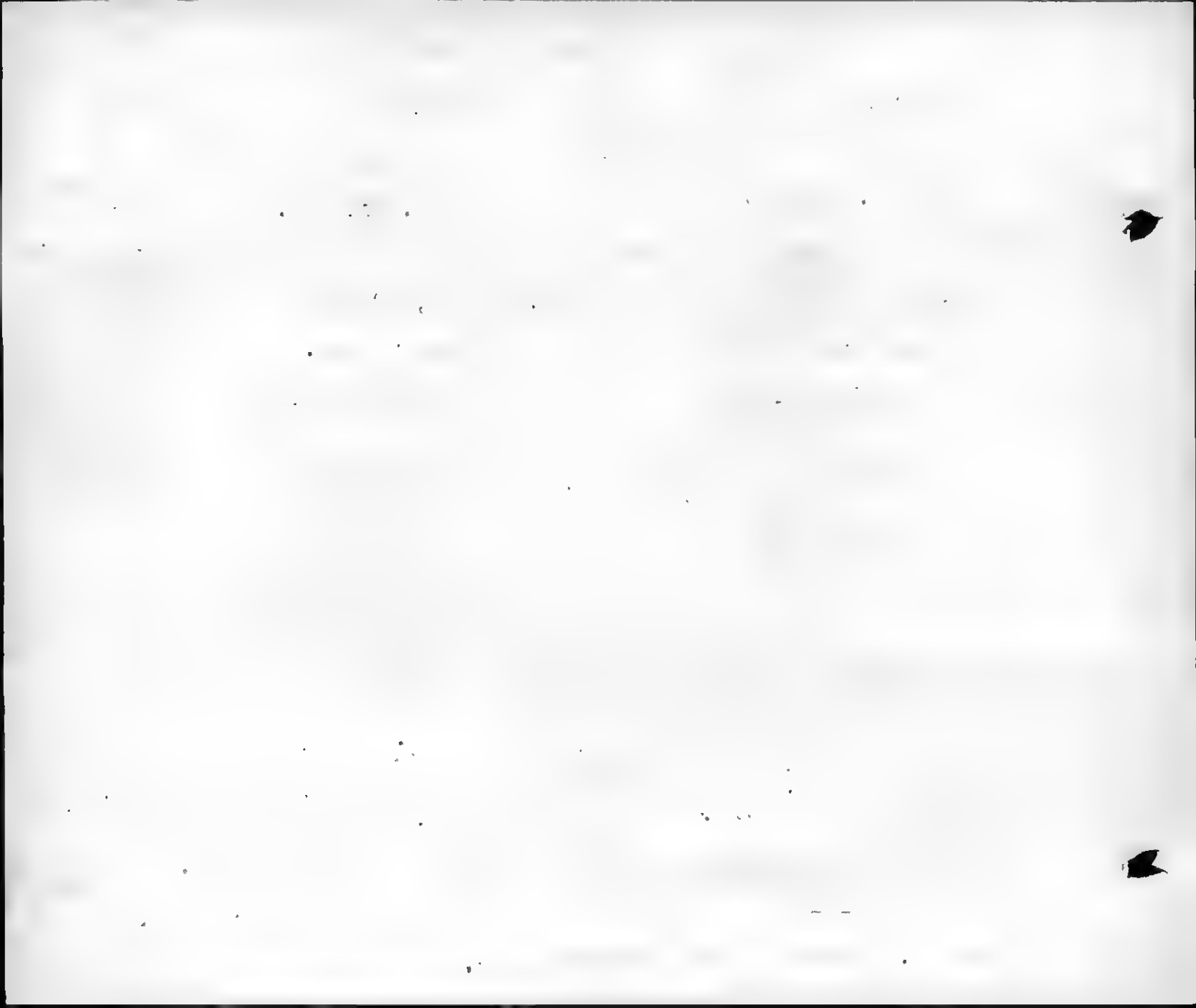
5106

## CERTIFICATE OF DEATH

05642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b> c. LENGTH OF STAY IN Tb <b>12 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>128 E. Main St</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg</b> d. STREET ADDRESS <b>128 E. Main St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Vena</b> Middle <b>Lee</b> Last <b>Furry</b>		4. DATE OF DEATH Month <b>April</b> Day <b>2</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 22, 1868</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Months <b>3</b> Days <b>4</b> Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Funkstown Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Furry</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Mc Coy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Atherosclerotic Heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 5, 1960</b> to <b>April 2, 1960</b> , that I last saw the deceased alive on <b>March 20, 1960</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. W. LeVan</b> M.D.		ADDRESS (Street, city or town, state) <b>Boonsboro</b> DATE SIGNED <b>4/2/60</b>	
PHYSICIAN'S NAME (Type) <b>Gerald Le Van</b>		<b>Boonsboro Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-4-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 5 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be needed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5033

Item 23 B- Film G-20 5/4/60 1wk

05043

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>15 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>24 Broadway</b>				e. STREET ADDRESS <b>24 Broadway</b>			
3. NAME OF DECEASED (Type or print) First <b>PROBERT</b> Middle <b>WOODFORD</b> Last <b>GRADY</b>				4. DATE OF DEATH Month <b>April</b> Day <b>29</b> Year <b>1960</b>			
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>May 8, 1897</b>	9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Electrical Wholesaler</b>		11 BIRTHPLACE (State or foreign country) <b>Goldsboro, N. Carolina</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry G. Grady</b>				14. MOTHER'S MAIDEN NAME <b>Claudia E. Perkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-05-6366</b>		17. INFORMANT Address <b>Mrs. Opal Grady Hagerstown, Maryland</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity, Exaggerated Skeletal Muscles</b>							
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>8-18-53</b> , 19____, to <b>4-29</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>4-29</b> , 19 <b>60</b> , and that death occurred at <b>2</b> M, from the causes and on the date stated above.							
22a SIGNATURE <b>Salmon M. Welty</b>				22b DATE SIGNED		22c PHYSICIAN'S NAME (Type) <b>SALMON M. WELTY</b>	
22d ADDRESS <b>998 Potomac Ave. Hagerstown, Md</b>				22e ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f DATE	
23a BURIAL, CREMATION, REMOVA (Specify) <b>Burial</b>		23b. DATE THEREOF <b>May 1, 1960</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b>				ADDRESS <b>Hagerstown, Md.</b>		25a REC'D BY REGISTRAR DATE <b>MAY 2 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

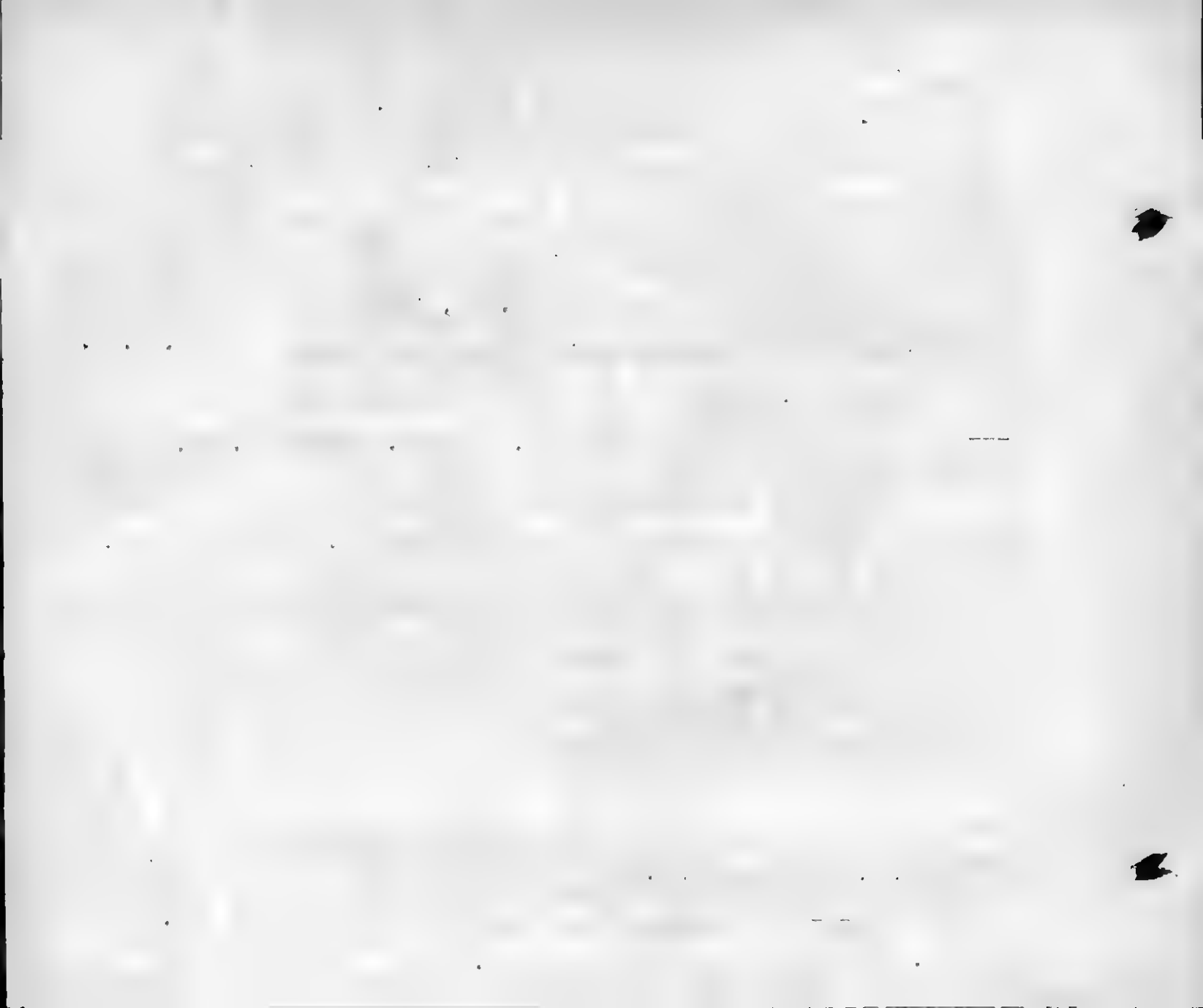
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05044

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 40 East</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			
				d. STREET ADDRESS <b>Route 1</b>			
3. NAME OF DECEASED (Type or print) First <b>Alfred</b> Middle <b>Gordon</b> Last <b>Graff</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1960</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 11, 1895</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House Building</b>			
11. BIRTHPLACE (State or foreign country) <b>Stratford Canada</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William H. Graff</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Zinn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>284-16-9202</b>			
17. INFORMANT <b>Mrs. Adela M. Graff</b>				Address <b>Hag. Rt. 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION, ATHEROSCLEROTIC</b>							
420.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (b) <b>MYOCARDIAL INFARCTION, POSTERIOR LT. VENTRICLE</b>							
DUE TO (c) <b>LEFT VENTRICULAR HYPERTROPHY</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>E. W. Ditto, Jr., M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>4/2/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-6-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>DATE APR 5 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>			

MEDICAL CERTIFICATE



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5084

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Film G261-4/27, 30-items 8 & 10-mmb

Reg. Dist. No.

05045

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>4 months</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Western Md. Chronic Disease Hosp.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>			
3. NAME OF DECEASED (Type or print) First <b>Dale</b> Middle <b>Frederick</b> Last <b>Graham</b>				4. DATE OF DEATH Month <b>4</b> Day <b>24</b> Year <b>1960</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/6/14</b> <b>5/6/1914</b>	9. AGE (In years last birthday) <b>45</b> yrs.	IF UNDER 1 YEAR Months <b>4</b> Days <b>24</b>	IF UNDER 24 HRS. Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi driver Cartographer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Graham</b>			14. MOTHER'S MAIDEN NAME <b>Bessie E. Fisher</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-07-4778</b>		17. INFORMANT Address <b>Application for admission-Western Md. Hosp.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia - lower lobes bilateral</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>126x</b> (a), stating the underlying cause last. DUE TO (c) <b>Fracture skull with cortical laceration.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Penetrating gunshot wound of head - self inflicted.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Penetrating gunshot wound of head - self inflicted</b>					
20c. TIME OF INJURY Month, Day, Year <b>3:00 PM 8-2 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Wheaton, Montgomery Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Edward W. Ditto, III</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto, III, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>4/25/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters</b>		ADDRESS <b>254 Capitol St NW</b>		24a. REC'D BY REGISTRAR <b>APR 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
22d. LOCATION (City, town, or county) (State) <b>Prince Georges County Maryland</b>							

111.11

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TO DEPUTY MEDICAL EXAMINER: This certificate shall be examined within 24 hours after death. If any delay is necessary, please excuse it by certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

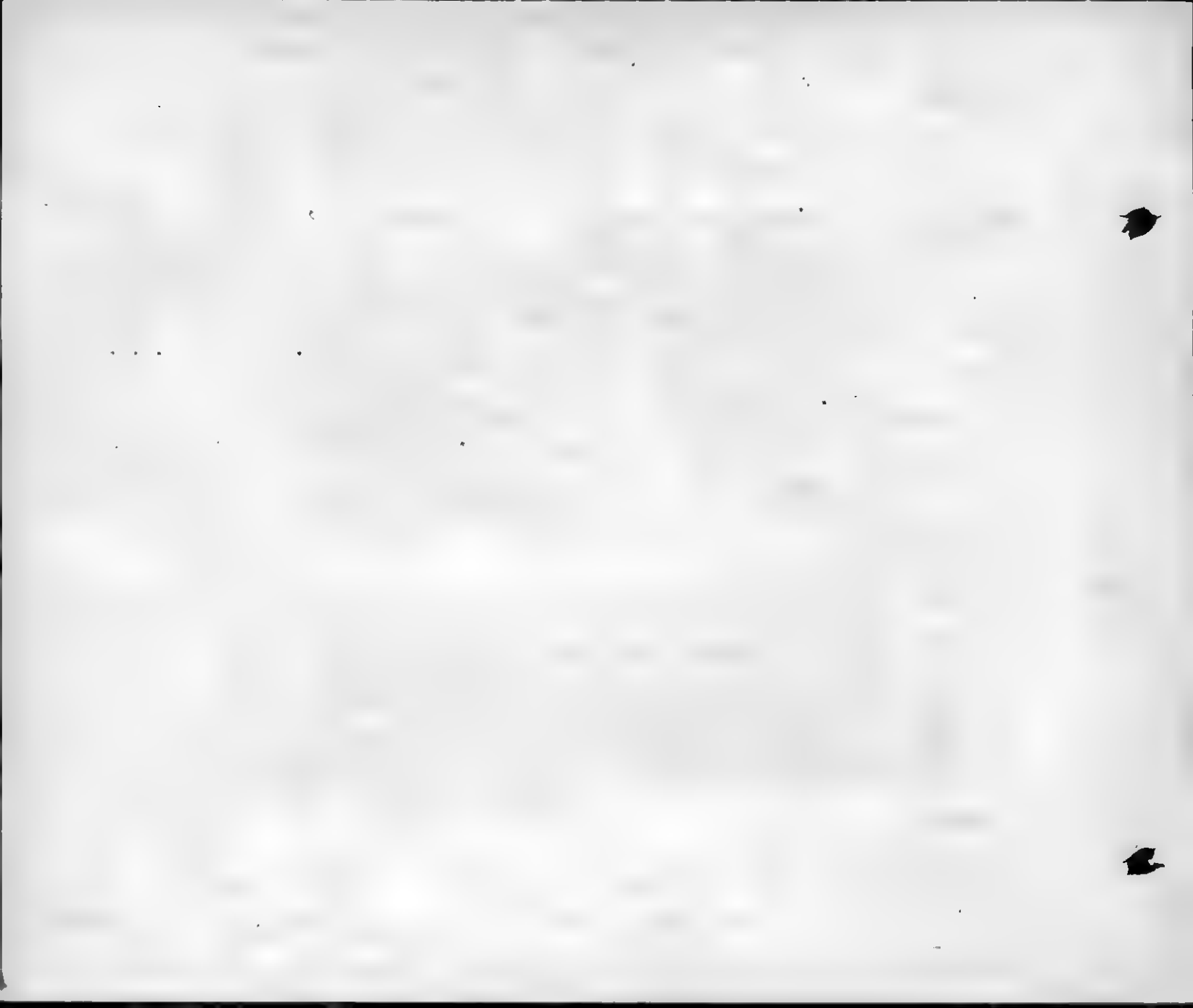
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>23 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>933 Summit Ave.</b>		e. STREET ADDRESS <b>933 Summit Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>WILKINSON</b> Last <b>GUILLARD</b>		4. DATE OF DEATH April Month Day Year <b>15 19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 21, 1897</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Repairer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Wells Tannery, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter M. Guillard</b>		14. MOTHER'S MAIDEN NAME <b>Drusilla ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Lester L. Guillard</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer - Neoplasm of Prostate</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Recent</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. E. W. L. T. J.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>D. E. W. L. T. J.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>4/16/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Suter-Rouzer Funeral Home</b> <b>Hagerstown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 20 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles L. Knecht</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

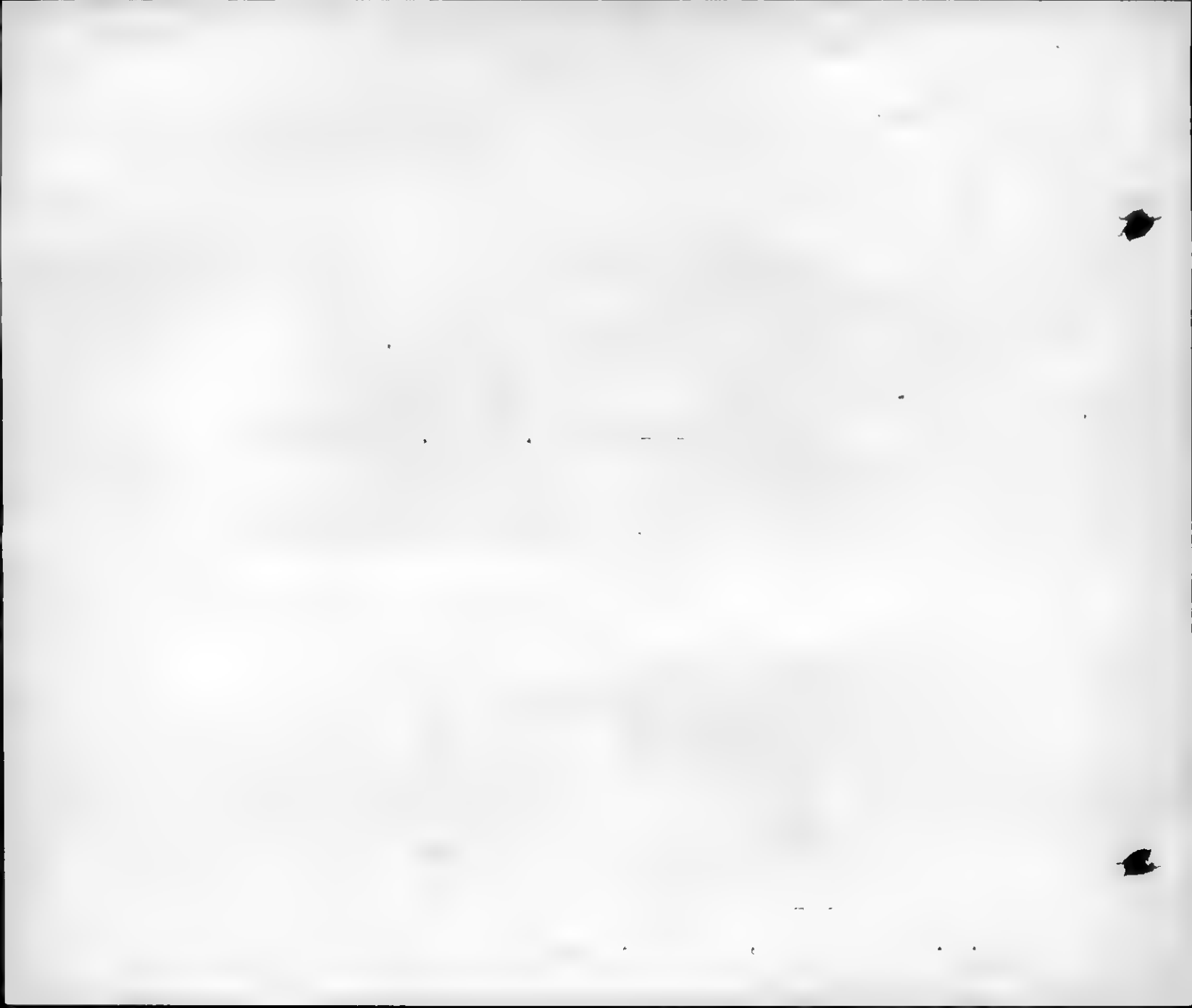
VR A15 (4)  
15M 9/59

5085

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05047

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Western Maryland State Hospital</b>		d. STREET ADDRESS <b>Near Frederick</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>KENT</b> Last <b>HARMON</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>7</b> Year <b>1960</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>18 Nov 1912</b>
9. AGE (In years last birthday) <b>47</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tenant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Nebo, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Rush F. Harmon</b>		14. MOTHER'S MAIDEN NAME <b>Ada Paxton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-26-1005</b>	
17. INFORMANT <b>Mrs. Julia E. Harmon (Same as item #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Label for pneumonia, bilateral</b> <b>744.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Progressive muscular Dystrophy</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>14 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>October 8, 1959</b> to <b>April 7, 1960</b> . That (I) (we) last saw the deceased alive on <b>April 7, 1960</b> and that death occurred at <b>6:18</b> M. from the causes and on the date stated above.			
22a. SIGNATURE <b>George Berou</b>		22b. DATE SIGNED <b>April 7, 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. GEORGE BEROU</b>		22d. ADDRESS <b>1500 PENNSYLVANIA AVE. HAGERSTOWN, MD.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4-11-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Frederick Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>APR 11 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>			

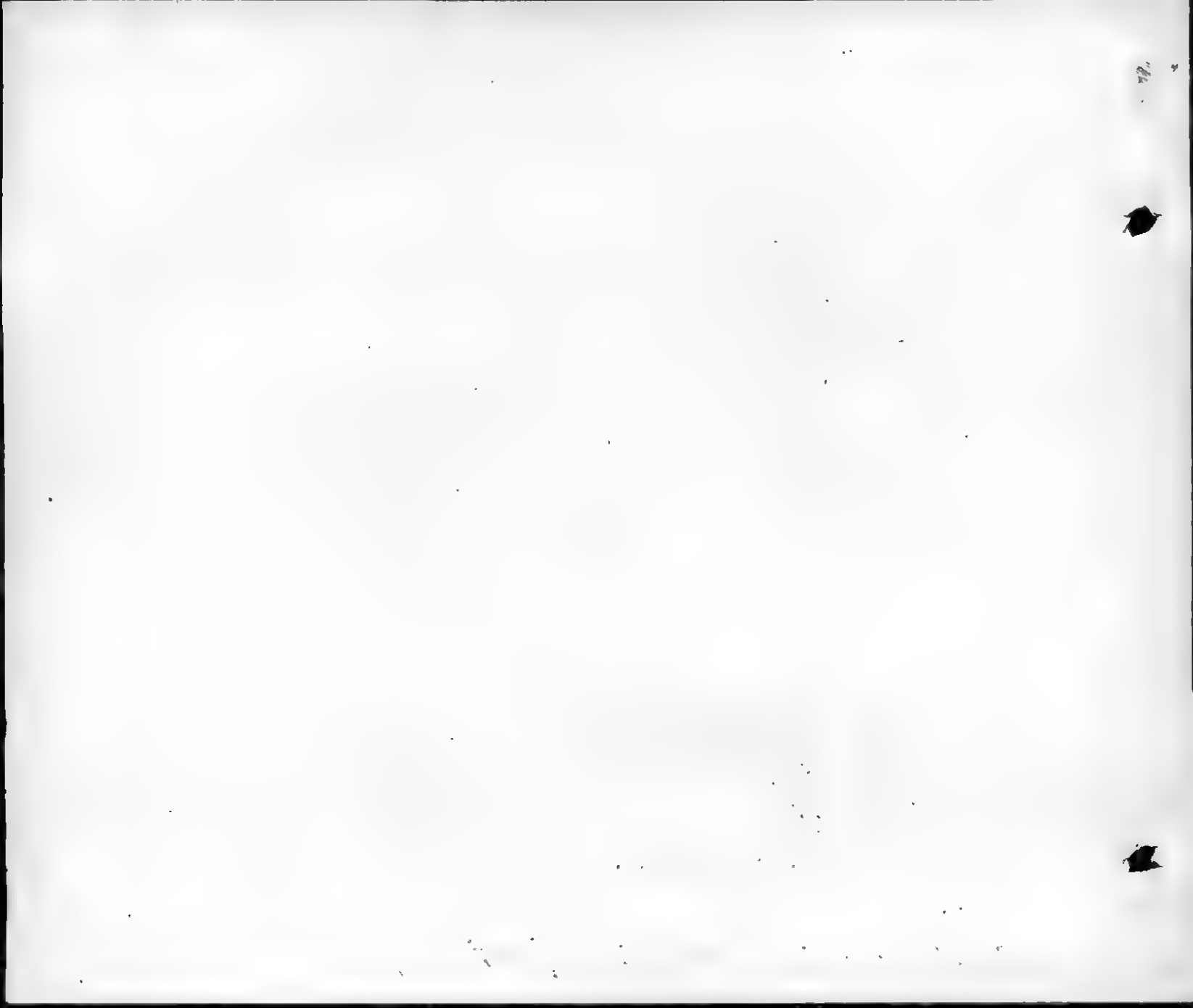


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5087**  
**CERTIFICATE OF DEATH**

05048  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			c. LENGTH OF STAY IN lb <b>50 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>1266 HAGLE ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHESTER</b> Middle <b>WILLIAM</b> Last <b>HARTLE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/11/1889</b>	
9. AGE (In years lost birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED OPERATOR</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>CITY WATER PLANT</b>			11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CLINTON HARTLE</b>				14. MOTHER'S MAIDEN NAME <b>MASIE SCHILDTNECHT</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-09-6978A</b>			
				Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Common Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis (Heart Disease)</b> DUE TO <b>Myocardium</b> (c) <b>Arteriosclerosis General</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 yrs.</b> <b>3 yrs.</b> <b>?</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15</b> , 19 <b>57</b> to <b>April 26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 9</b> , 19 <b>60</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. 159 W. Washington St. Hagerstown</b> DATE SIGNED <b>4/27/60</b> ACTUAL SIGNATURE <b>Philip J. Hirshman</b> PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/29/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>R. ST. HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horne</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 2 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Koser</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

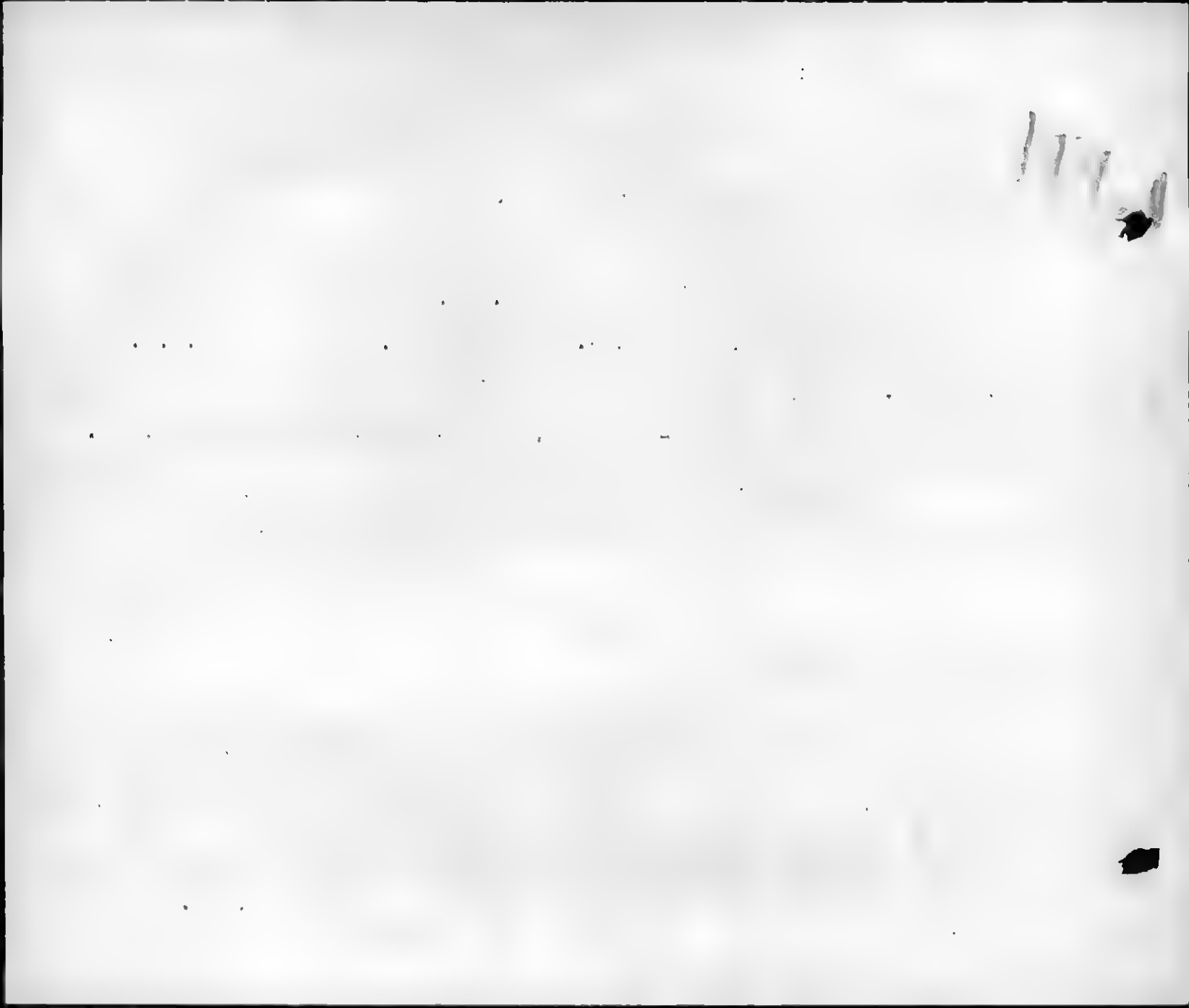
VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5098

05049

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>5 weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Kitzmiller</b> d. STREET ADDRESS <b>Star Route</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>M.</b> Last <b>HARVEY</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1871</b> 9. AGE (In years birthday) <b>88</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer, Coal mines, Farm, Etc.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James W. Harvey</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Murphy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT Address <b>Mrs. William Harvey Kitzmiller, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>LOBULAR PNEUMONIA LOWER LOBES BILATERAL</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <b>CARCINOMA OF PROSTATE WITH METASTASES</b> DUE TO (c) <b>SQUAMOUS CELL CARCINOMA OF SKIN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 DAYS</b> <b>10 YRS.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>SQUAMOUS CELL CARCINOMA OF SKIN</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>MAR. 11, 1960</b> to <b>APRIL 16, 1960</b> , that (I) (we) last saw the deceased alive on <b>APRIL 16, 1960</b> , and that death occurred on <b>APR 16, 1960</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>George Bercu</b>		22b. DATE SIGNED <b>4/16/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. GEORGE BERCU</b>		22d. ADDRESS <b>1500 PENNSYLVANIA AVE, HAGERSTOWN, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>		23d. LOCAT ON (City, town, or county) (State) <b>Deer Park, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Leighton Cookland M.D.</b>		25a. REC'D BY REGISTRAR <b>APR 19 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



5089

## CERTIFICATE OF DEATH

Reg. Dist. No. 05050

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>7 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Myersville</u>	
		d. STREET ADDRESS <u>Route # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>K.</u> Last <u>HAYS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>23</u> Year <u>1960</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 7, 1884</u>
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min <u>76</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own chicken farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Allen Hays</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Kline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-12-2404</u>	
17. INFORMANT <u>Mrs. Oscar Delauter</u>		Address <u>Rt. # 2</u> <u>Myersville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>o m.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-12-59</u> 19, to <u>4-22-60</u> 19, that I last saw the deceased alive on <u>4-22-60</u> 19, and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>4-22-60</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>		<u>Smithsburg, Md.</u>	
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Apr. 26, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mark's Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Wolfsville, Fred. Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>		24a. REC'D BY REGISTRAR <u>APR 28 '60</u>	
ADDRESS <u>Myersville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles F. Hess</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then place remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

425-1



5093

## CERTIFICATE OF DEATH

Reg. Dist. No.

05051

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Henson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 13, 1960</b>
9. AGE (In years lost birthday) yrs. <b>7</b>		10. IF UNDER 1 YEAR: Months <b>7</b> Days <b>24</b> Hours <b>24</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Bud Hutzell</b>		14. MOTHER'S MAIDEN NAME <b>Bettie Elizabeth Henson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Harry Thurman Henson</b>		18. ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b>	
19. R.F.D. #1 <b>R.F.D. #1</b>		20. INTERVIEW BETWEEN ONSET AND DEATH <b>Day</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>773.0</b> IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/13/60</b> to <b>4/14/60</b> , that I last saw the deceased alive on <b>4/14/60</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b> DATE SIGNED <b>4/15/60</b> ACTUAL SIGNATURE <b>Robert Young</b> M.D. <b>William J. Foster</b> PHYSICIAN'S NAME (Type) <b>Robert Young</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 16, '60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bakersville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Lee</b>		24a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

5108

5108

CERTIFICATE OF DEATH

05052

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport</u> c. LENGTH OF STAY IN 1b <u>2 years 6 months</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hampton Road West</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Williamsport (Mt. Tammany)</u> d. STREET ADDRESS <u>Hampton Road West</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MAURICE</u> <u>EDGAR</u> <u>HESS</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 22, 1874</u> 9. AGE (In years last birthday) <u>85</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture Manufactory</u> <u>Taneytown, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Hess</u>		14. MOTHER'S MAIDEN NAME <u>Agnes J. Baker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-6930</u>	
17. INFORMANT <u>Mrs. Margaret Hess Williamsport, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic cardio-vascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Benign hypertrophy of prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 16, 1960</u> to <u>April 17, 1960</u> that (I) (we) last saw the deceased alive on <u>April 16, 1960</u> and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Walter Layman</u> M.D.		22b. DATE SIGNED <u>April 18, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Walter Layman, M. D.,</u>		22d. ADDRESS <u>Hagerstown, Maryland</u> <u>100 Professional Arts Bldg.,</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/19/1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Houzer Funeral Home</u> <u>B. Houder</u>		25a. REC'D BY REGISTRAR <u>APR 21 '60</u>	
ADDRESS <u>Hagerstown, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Houder</u>	



05053

5021  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MATYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>60 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>266 S. POTOMAC ST.</b>		e. STREET ADDRESS <b>266 S. POTOMAC ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>JONAS</b> Middle <b>LEE</b> Last <b>HOCKMAN</b>		4. DATE OF DEATH Month <b>APRIL</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/7/1865</b>
9. AGE (In years last birthday) <b>94 yrs.</b>		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>10</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JONAS LEE HOCKMAN</b>	
14. MOTHER'S MAIDEN NAME <b>ELIZA COVERSTONE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not known) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NONE</b>		INFORMANT <b>MRS CLARA H. KARN</b> <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease.</b> DUE TO (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 9, 1960</b> to <b>April 10, 1960</b> that I last saw the deceased alive on <b>April 9, 1960</b> and that death occurred at <b>9:19 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. A. Bell</b>		ADDRESS (Street, city or town, state) <b>119 N. Potomac Street, Hagerstown, Maryland.</b>	
PHYSICIAN'S NAME (Type) <b>R. A. BELL, M.D.</b>		DATE SIGNED <b>4/12/60.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/13/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horowitz, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Christina S. Kraus</b>

4-6

4-6

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5025

05054  
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		d. STREET ADDRESS <u>435 W. FRANKLIN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>EARL FRANKLIN HOLMES</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 2 - 1897</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u>	
11. BIRTHPLACE (State or foreign country) <u>FAIRCHILD AIRPORT CHESTNUT GROVE WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NELSON HOLMES</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES</u> <u>W.W. I</u>		16. SOCIAL SECURITY NO. <u>220-09-9134</u>	
17. INFORMANT <u>MRS. ESTA HOLMES</u>		Address <u>435 W. FRANKLIN ST. HAGERSTOWN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u> DUE TO (c) <u>General arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>5 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>...</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. E. W. H. T. O. P.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 8, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Baer</u>		24a. REC'D BY REGISTRAR <u>APR 12 1960</u>	
ADDRESS <u>BOONSBORO MD.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

2602

W. R. L.  
- W. H. T.  
REST  
151



5092

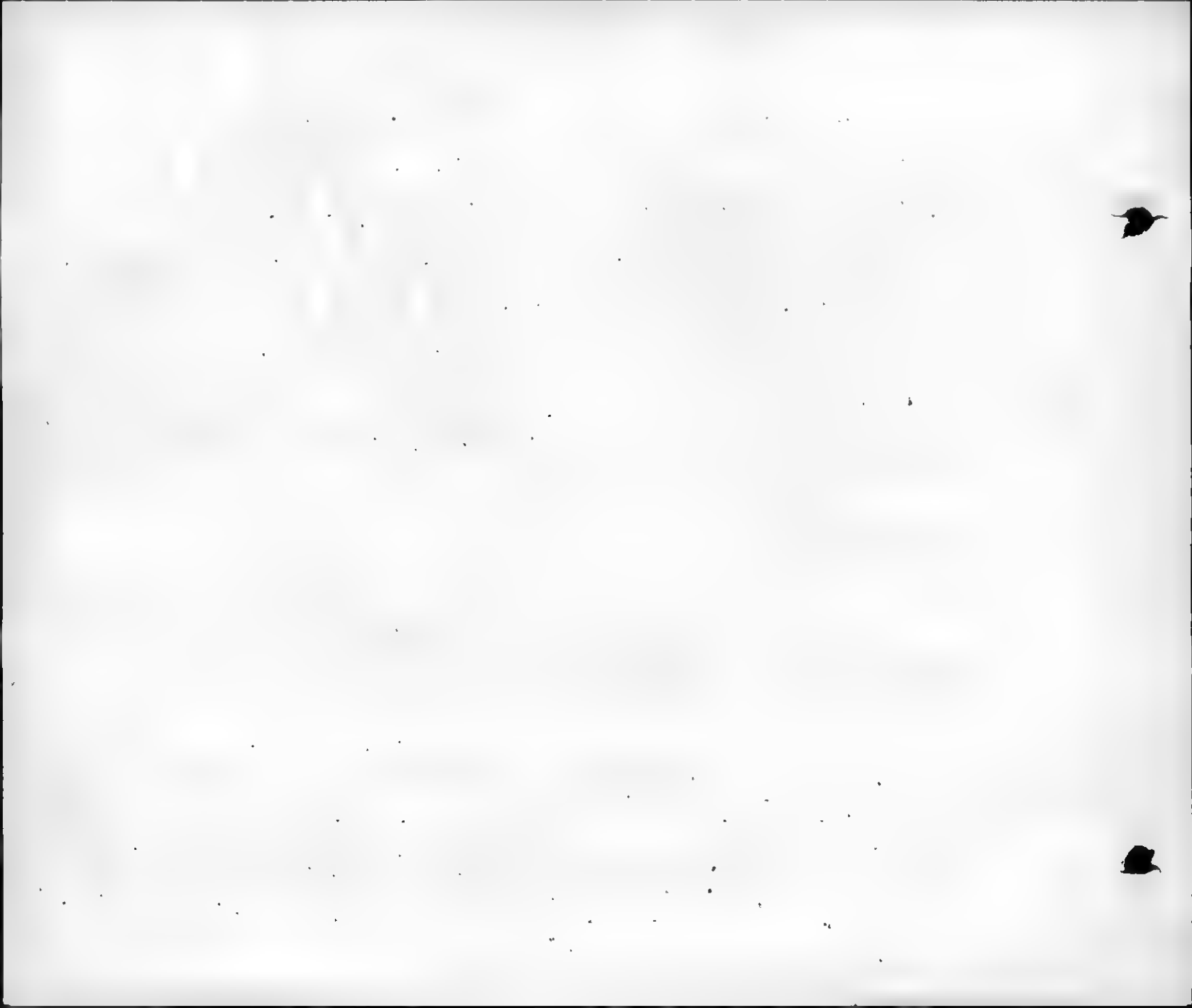
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Greencastle</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> <u>5 mi</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> <u>75</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>Homer</u>		4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 9, 1883</u> 76 yrs.
9. AGE (In years last birthday) <u>76</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Greencastle, Pennsylvania U.S.A.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>D. W. Homer</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Feldman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Mrs. Mary Homer - Greencastle, Pa.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4.42X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
18. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>60</u> to <u>April 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April 26</u> , 19 <u>60</u> , and that death occurred at <u>10 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. E. Byrkit</u> M.D.		ADDRESS (Street, city or town, state) <u>284 Potomac</u> DATE SIGNED <u>4-26-60</u>	
PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u> <u>Williamsport</u> <u>Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> <u>4/29/60</u>		22b. DATE THEREOF <u>4/29/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>near Greencastle Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Munnich</u> ADDRESS <u>Greencastle</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05056  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN lb <b>3YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HANCOCK</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARLOCK ALL. CONV. HOSPITAL</b>				d. STREET ADDRESS <b>HANCOCK RT. #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SUSAN JANE HULL</b>				4. DATE OF DEATH Month Day Year <b>APRIL 25 19 60</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/12/1873</b>		9. AGE (In years last birthday) <b>86 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS SNYDER</b>				14. MOTHER'S MAIDEN NAME <b>JANE BISHOP</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. THOMAS J. HULL</b>		Address <b>RT. #2 HANCOCK MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>471X</b> IMMEDIATE CAUSE (a) <b>Lobular pneumonia</b> DUE TO <b>Bilateral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Inter-trochanteric Fracture Right Femur—(Hip)</b>							INTERVAL BETWEEN ONSET AND DEATH <b>one week</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell while going to toilet.</b>					
20c. TIME OF INJURY Hour <b>10:45</b> p.m. Month, Day, Year <b>Nov 4 1960</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, off co bldg., etc.) <b>Garlock Home</b>		20f. (City or town) (County) (State) <b>Hagerstown, Wash. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>4/26/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>STONE BRIDGE CHURCH</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>U. J. McManis Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>APR 29 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. Kline</b>	

TO DISTRIBUTE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a separate certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



5027

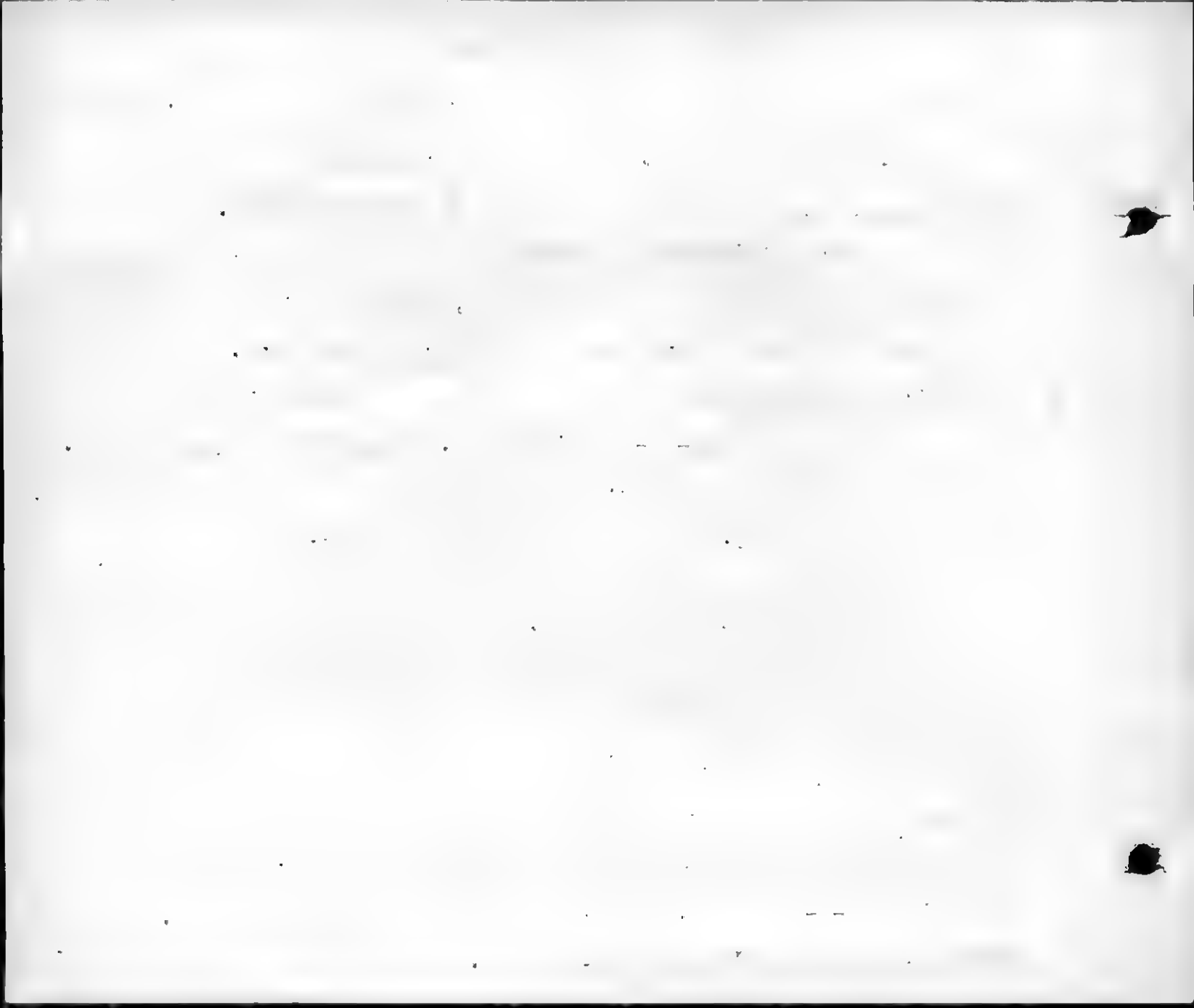
## CERTIFICATE OF DEATH

05057  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>55 years</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>915 Hamilton Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gail Elizabeth Ilgenfritz</b> First Middle Last 4. DATE OF DEATH <b>April 2 1960</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>May 10, 1892</b> 9. AGE (In years last birthday) <b>67</b> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b> 11. BIRTHPLACE (State or foreign country) <b>Chambersburg Penn.</b> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Colliflower</b>		14. MOTHER'S MAIDEN NAME <b>Mary Frederick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-32-4856</b> INFORMANT <b>Howard E. Ilgenfritz</b> Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>420.1</b> DUE TO (b) <b>Coronary Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Heart Disease with Mitral Insufficiency - 60 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>12 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1946</b> to <b>April 2, 1960</b> , that I last saw the deceased alive on <b>April 2, 1960</b> , and that death occurred at <b>7:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>998 Potomac Ave Hagerstown Md.</b> DATE SIGNED <b>4-3-60</b>			
ACTUAL SIGNATURE <b>Dalton M. Welty</b> M.D.		PHYSICIAN'S NAME (Type) <b>DALTON M. WELTY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-5-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>APR 5 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



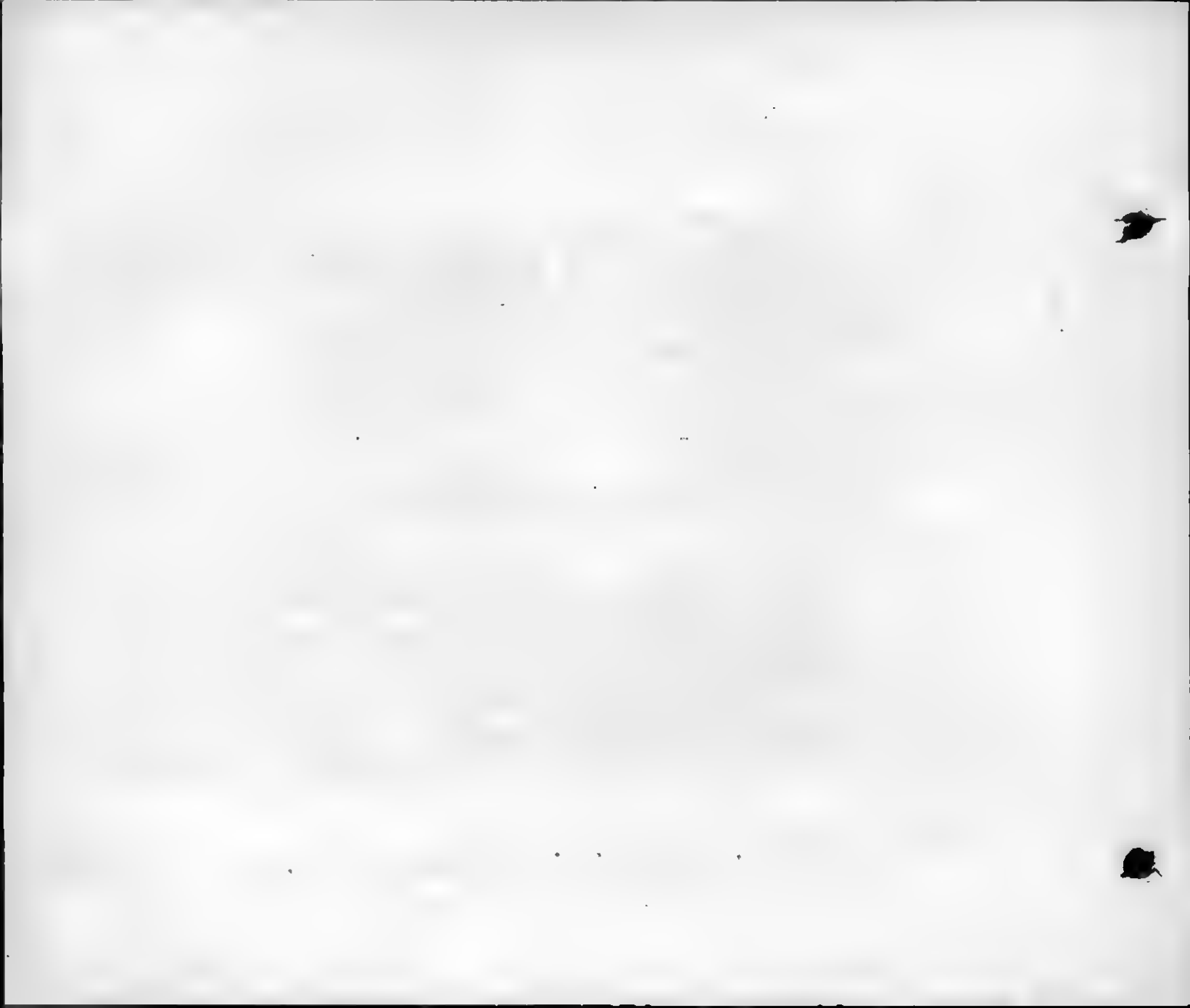
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5109

05058

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dargan</b>		c. LENGTH OF STAY IN 1b <b>65 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Own Residence</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dargan</b>	
		d. STREET ADDRESS <b>Dargan Road</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>ARNOLD</b> Last <b>INGRAM</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1894</b>
9. AGE (In years last birthday) <b>66 yrs</b>		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>00</b> Hours <b>00</b> Min <b>00</b>	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Bakerton, West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles William Ingram</b>		14. MOTHER'S MAIDEN NAME <b>Annie Gertrude Welsh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-10-3654</b>	
17. INFORMANT <b>Mrs. Margaret Ingram</b>		RFD # <b>1</b> , Harpers Ferry, West Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatoid arthritis</b> DUE TO <b>722.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____			INTERVAL BETWEEN ONSET AND DEATH <b>10 Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 _____, to <b>4/9/60</b> , 19 _____, that (I) (we) last saw the deceased alive on <b>4/8/60</b> , 19 _____, and that death occurred at <b>7:20 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter H. Shealy</b>		22b. DATE SIGNED <b>4/9/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>		22d. ADDRESS <b>Sharpsburg, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4/12/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Samples Manor Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Samples Manor, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>A. Donald Eckles</b>		25a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>William S. Turner</b>			





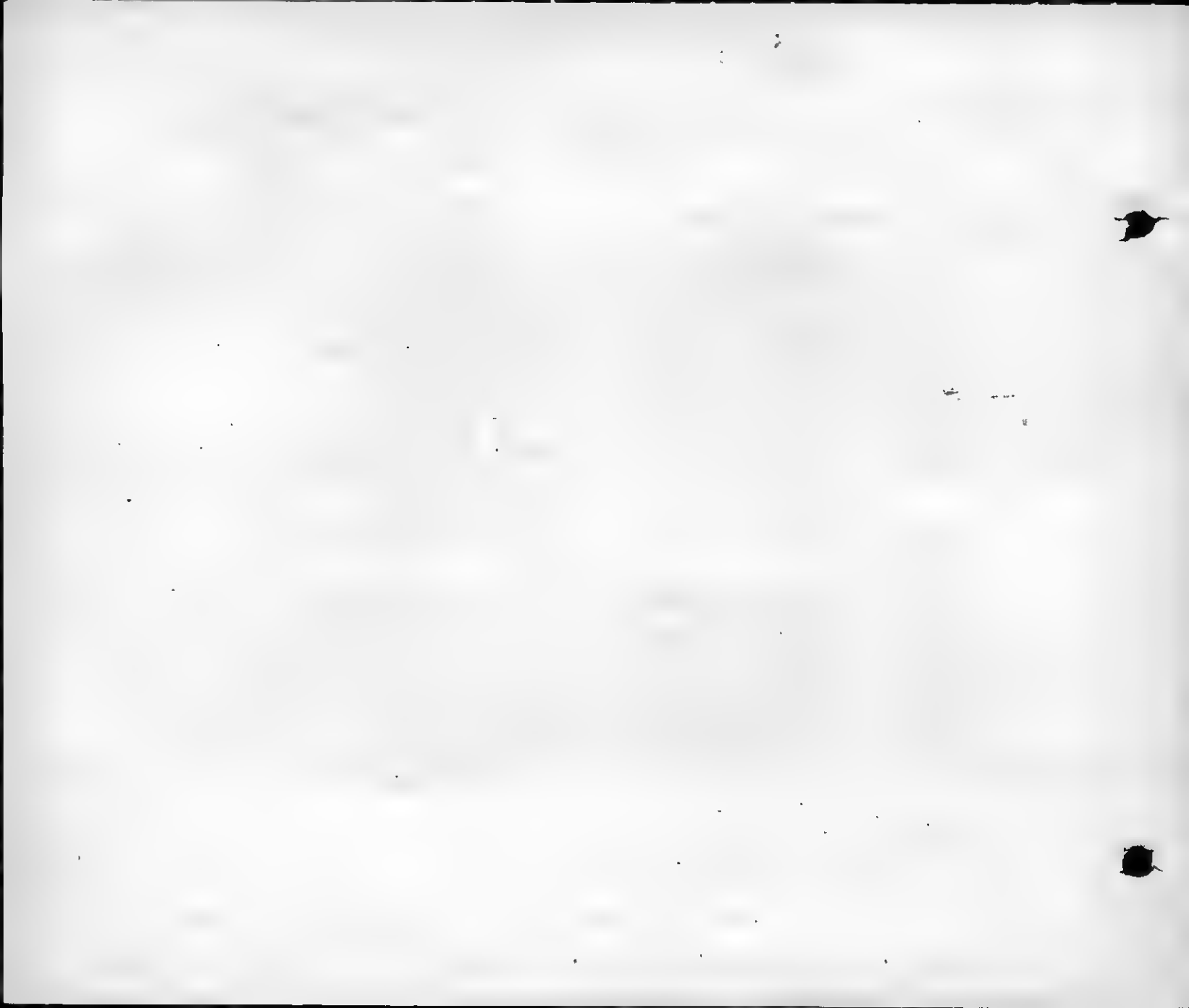
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ISM 9/59

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5028  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05059  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>5 Days</b> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R # 4</b> d. STREET ADDRESS <b>Greencastle Pike</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>LOUISE</b> Last <b>IRVIN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8 1890</b>	9. AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months <b>3</b> Days <b>4</b>	IF UNDER 24 HRS Hours <b>4</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Paulsgrove</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Hose</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Jos M. Irvin Hagerstown Md. R # 4</b> Address <b>Greencastle Pike</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>415X</b> DUE TO <b>Renal shutdown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>Pneumonia + Congestive Heart Failure</b> DUE TO <b>4dy</b> (c) <b>3dys</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3dys</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cachexia</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month <b>March</b> Day <b>12</b> Year <b>1960</b> Hour <b>o. m.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 12 1960</b> to <b>April 4 1960</b> that (I) (we) last saw the deceased alive on <b>April 4 1960</b> and that death occurred at <b>PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>M. E. Byrkit</b>		M. D. <b>X</b>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>4-5-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>M. E. Byrkit</b>		22d. ADDRESS <b>28 W Potomac Wharf Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Apr 7 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Pauls Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>near Clear Spring Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				25a. REC'D BY REGISTRAR <b>APR 7 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



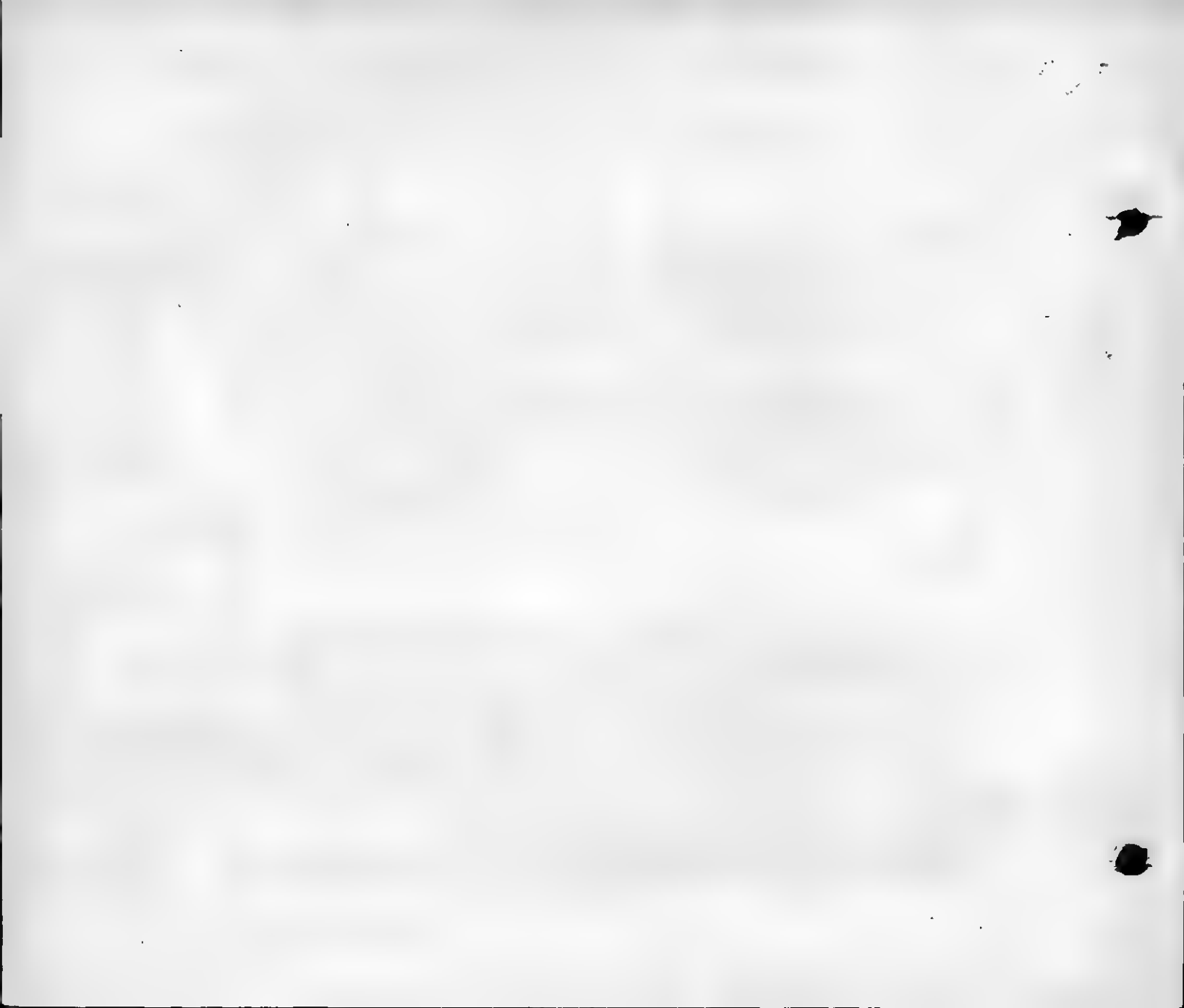
## CERTIFICATE OF DEATH

Reg. Dist. No. 05060

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RT 1 Clear Spring</u>		c. LENGTH OF STAY IN IT <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural RT 1.</u>		d. STREET ADDRESS <u>RT 2</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Keefe</u> Middle <u>R</u> Last <u>R</u>		4. DATE OF DEATH <u>April 19, 1960</u> Month <u>April</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR <u>6</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Isaac Keefe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hedy Cutchall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Carl Keefe</u> Address <u>RT 2 Greencastle, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO <u>Arterio Sclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 yrs.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Marked Inguinal Hernia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar 20, 1960</u> to <u>April 19, 1960</u> , that I last saw the deceased alive on <u>April 18, 1960</u> , and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.		ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u> DATE SIGNED <u>4/20/60</u>	
PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BRETHREN CH. CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HANCOCK, Md. P. Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Livingstone Mercersburg, Pa.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



5029

## CERTIFICATE OF DEATH

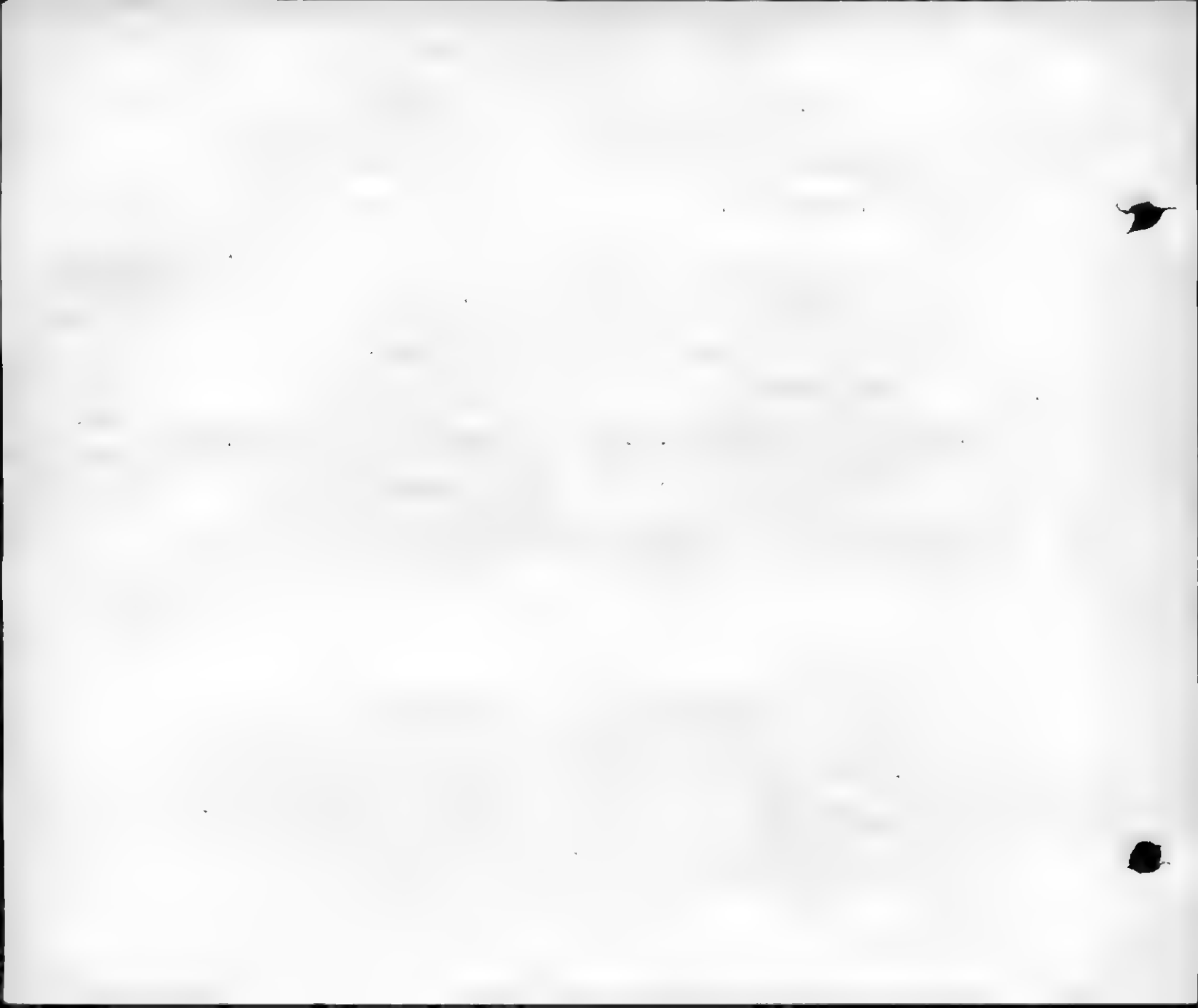
05061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>10 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>708 W. Franklin St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>STANLEY</b> Last <b>KETTERMAN</b>		4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1888</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.	11. IF UNDER 24 HRS Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Board of Education</b>	
11. BIRTHPLACE (State or foreign country) <b>Pen Mar, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Ketterman</b>		14. MOTHER'S MAIDEN NAME <b>Mary Sherman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>214-09-3199</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO (c) <b>Arterio-sclerotic Heart Disease</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>April 2, 1960</b>		20. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 12, 1958</b> to <b>April 4, 1960</b> that I last saw the deceased alive on <b>April 4, 1960</b> and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>	
23. ACTUAL SIGNATURE <b>Sidney Novenstein</b> M.D.		24. DATE SIGNED <b>4-4-60</b>	
25. PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>		26. DATE THEREOF <b>4/6/60</b>	
27a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		27b. DATE THEREOF <b>4/6/60</b>	
27c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		27d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
28. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		29. ADDRESS <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>	
30. REC'D BY REGISTRAR <b>APR 6 '60</b>		31. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute and file this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 18 Film 262 5-5-55 5030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 05663										
1. PLACE OF DEATH a. COUNTY <u>JOHNS HOPKINS</u> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>JOHNS HOPKINS</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOHNS HOPKINS</u>			c. LENGTH OF STAY IN TB <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOHNS HOPKINS</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>JOHNS HOPKINS HOSPITAL</u>					d. STREET ADDRESS <u>JOHNS HOPKINS BLVD.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JOHNS</u> Middle <u>H.</u> Last <u>NOTT</u>					4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1960</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 13, 1915</u>		9. AGE (in years last birthday) <u>45</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT CRAFT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT CRAFT</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>C. NOTT</u>					14. MOTHER'S MAIDEN NAME <u>CLARINE DUFFY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-16-1941</u>		17. INFORMANT <u>JOHNS HOPKINS</u>			Address <u>JOHNS HOPKINS, D.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of Vomitus</u> <u>353.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Epilepsy</u> (a), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>20 Years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>[Signature]</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>JOHN W. H. T. T. J.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>			22b. DATE THEREOF <u>4/11/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS</u>		22d. LOCATION (City, town, or county) (State) <u>JOHNS HOPKINS, D.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN W. H. T. T. J.</u>					ADDRESS <u>JOHNS HOPKINS, D.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kneale</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

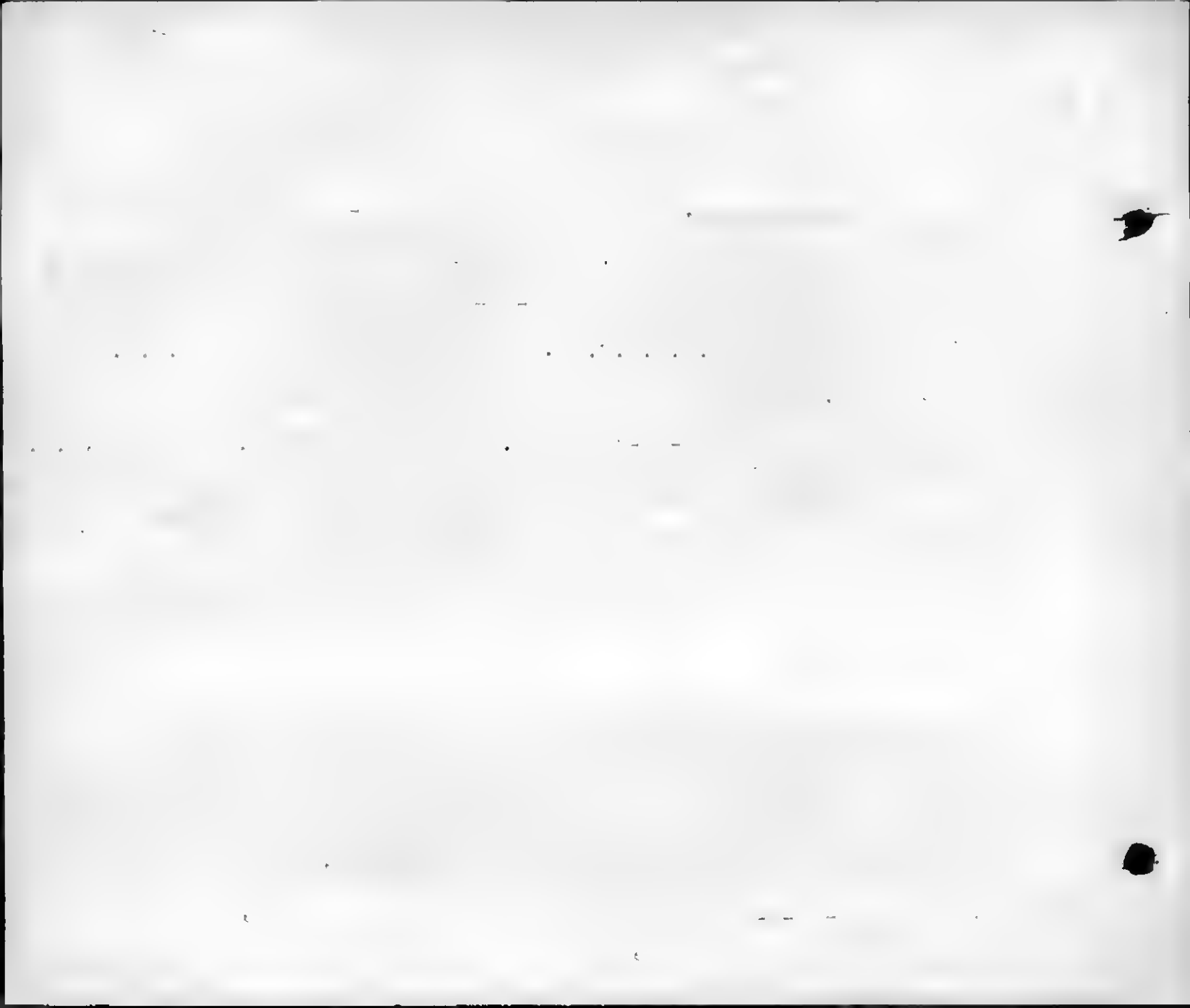
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

5031

05064

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brownsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>-</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Turner</b> Middle <b>P.</b> Last <b>Luttrell</b>				4. DATE OF DEATH Month <b>4</b> Day <b>29</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-10-1876</b>	
9. AGE (In years last birthday) <b>84</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B.&amp;O.R.R.Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Richard H. Luttrell</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Jane Lawyer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-12-1907</b>		17. INFORMANT Address <b>Mrs. Victoria Hovermale, Washington, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Constrictive Heart Failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-25-1960</b> to <b>4-28-1960</b> , that (I) (we) last saw the deceased alive on <b>4-28-1960</b> , and that death occurred at <b>6:04 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph Secundari</b>				22b. DATE SIGNED <b>M D</b>		22c. PHYSICIAN'S NAME (Type) <b>JOSEPH SECONDA RI</b>	
22d. ADDRESS <b>Boonesboro, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>5-5-1-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>		23d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Br. H. Feller</b>				25a. REC'D BY REGISTRAR DATE <b>MAY 3 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

5093

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05065

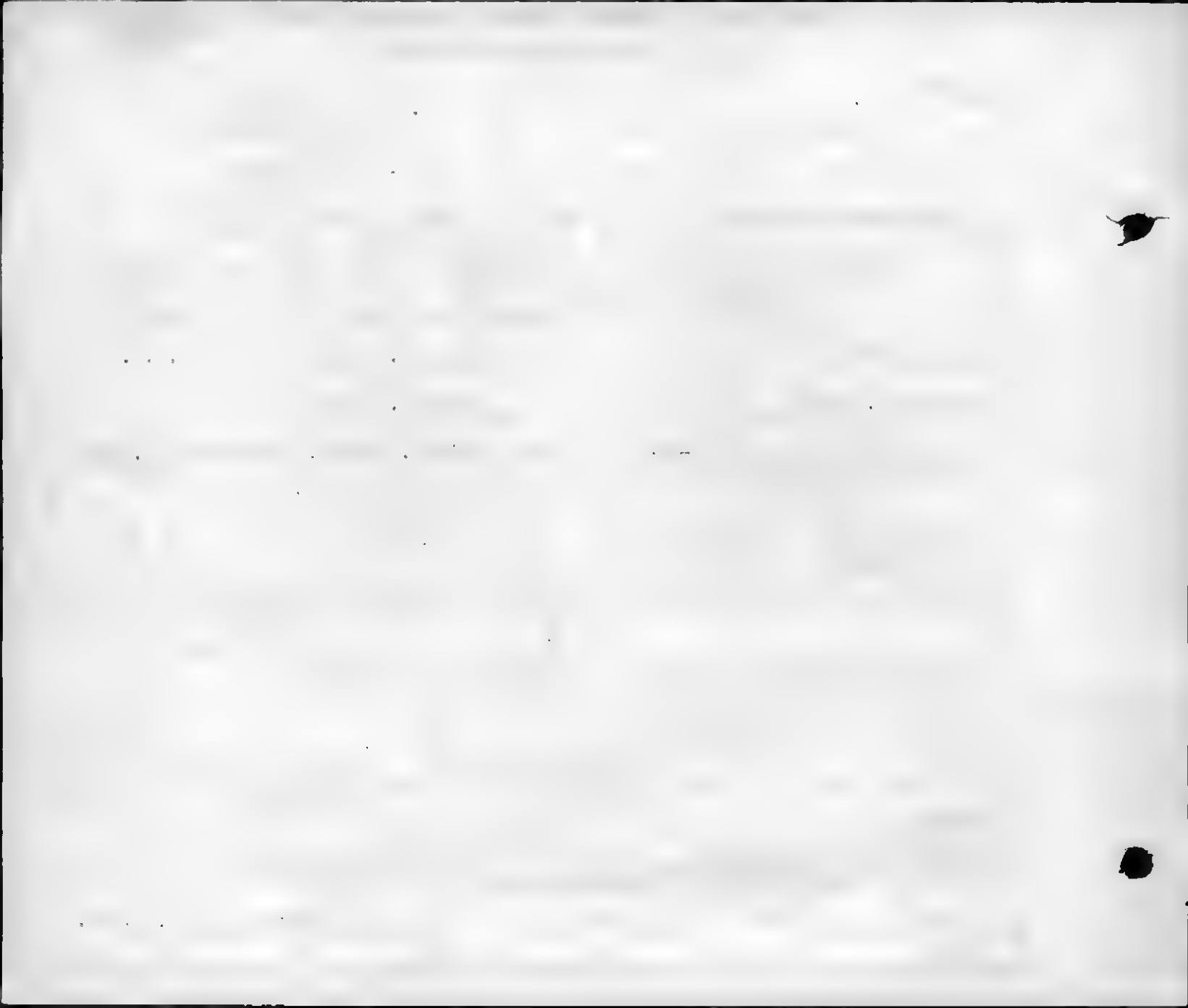
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		c. LENGTH OF STAY IN 1b <b>Williamsport</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>25 S. Vermont Street</b>		e. STREET ADDRESS <b>25 S. Vermont Street</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAZIE</b> Middle <b>MAY</b> Last <b>MARKER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1918</b>
9. AGE (In years last birthday) <b>41</b> yrs		10. IF UNDER 1 YEAR Months <b>41</b> Days <b>12</b> Hours <b>19</b> Min <b>60</b>	11. IF UNDER 24 HRS Months <b>41</b> Days <b>12</b> Hours <b>19</b> Min <b>60</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Williamsport District, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alva J. Lamp</b>		14. MOTHER'S MAIDEN NAME <b>Rose M. Fowler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>R. Ponytz Marker</b>		Address <b>Williamsport, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute myocardial infarction (presumptive)</b> 420.1 DUE TO <b>Coronary Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Coronary Heart Disease</b> (c) DUE TO <b>Coronary Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Five minutes</b> <b>About 4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Heart Disease, inactive</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-16, 1955</b> to <b>4-12, 1960</b> , that (I) (we) last saw the deceased alive on <b>3/15, 1960</b> , and that death occurred at <b>10:15 AM</b> on the causes and on the date stated above			
22a. SIGNATURE <b>John H. Hornbaker</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>		22d. ADDRESS <b>154 West Washington St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Funeral</b>		23b. DATE THEREOF <b>4/16/1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Williamsport, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Ronzer Funeral Home</b>		25a. REC'D BY REGISTRAR <b>APR 18 '60</b>	
ADDRESS <b>Hagerstown, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

420.1

## 5032 CERTIFICATE OF DEATH

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural, Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		M. STREET ADDRESS Smithsburg #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Naomi First Cynthia Middle Marker Last		4. DATE OF DEATH April		Month Day Year 10, 19 60	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6/4/1902		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Reed Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles E. Marker		14. MOTHER'S MAIDEN NAME Sarah E. Harshman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-36-6972		17. INFORMANT Miss Edith K. Marker, Smithsburg Md., #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTERMURAL HEMORRHAGE, left CORONARY ARTERY 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hour 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES Mellitus Obesity		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from April 6, 1960, to April 10, 1960, that I last saw the deceased alive on April 9, 1960, and that death occurred at 8:50 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE E. R. Luedke		M.D. 12 South Main St		DATE SIGNED 4-10-60	
PHYSICIAN'S NAME (Type) E. R. Luedke		Smithsburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/13/60		22c. NAME OF CEMETERY OR CREMATORY Smithsburg	
22d. LOCATION (City, town, or county) Smithsburg, Washington, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR APR 12 1960	
24b. REGISTRAR'S SIGNATURE					



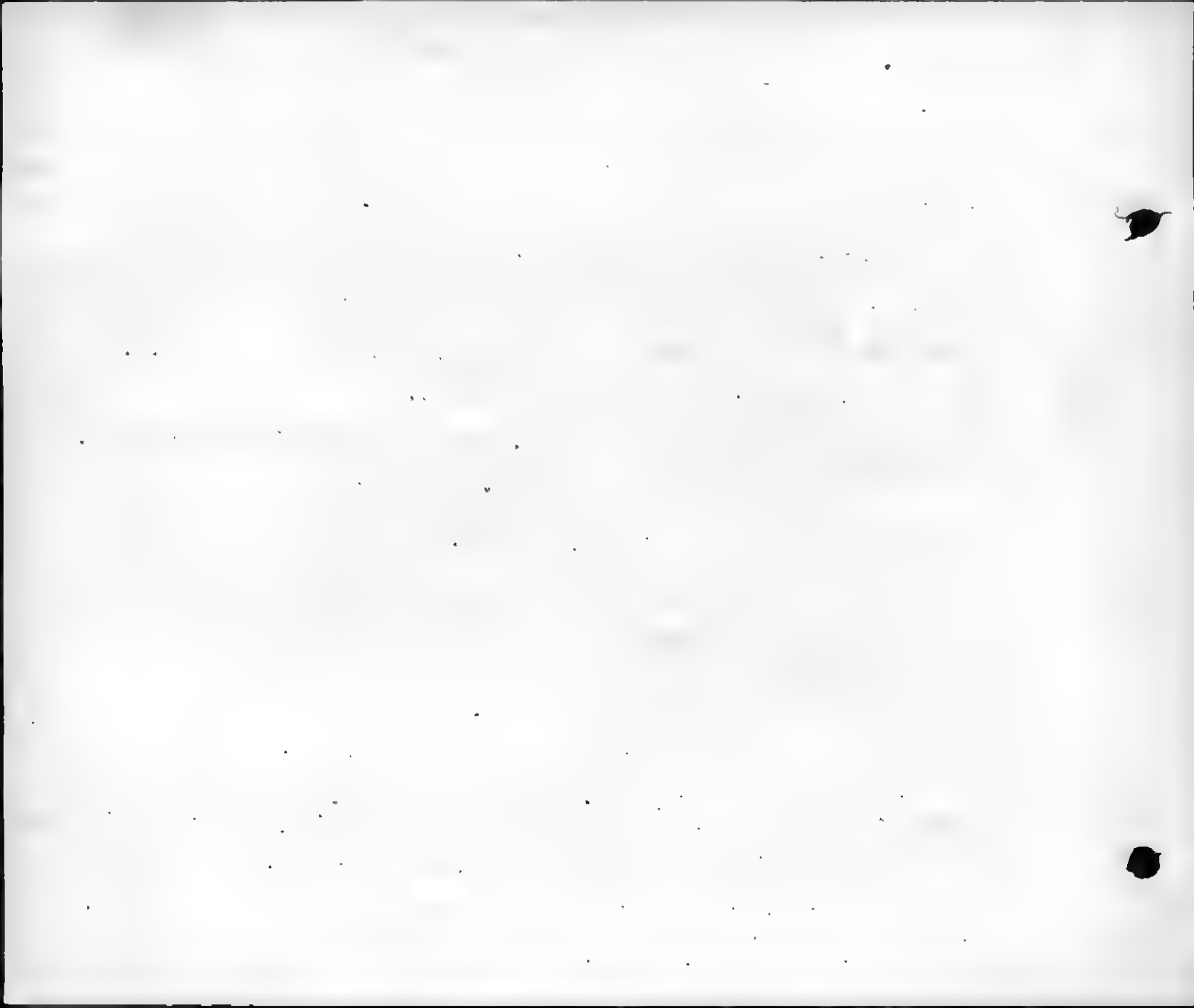
5094

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>4 yrs 5 mos 18 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1 Route #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Amie</u> Middle <u>Martin</u> Last <u>Martin</u>		4. DATE OF DEATH Month <u>April</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 29 1883</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Leitersburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Joseph Martin</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Clapper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Marion Hartle Williamsport Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month <u></u> Day <u>19</u> Year <u>19</u> Hour a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>59</u> to <u>April 28</u> 19 <u>60</u> that I last saw the deceased alive on <u>April 27</u> , 19 <u>60</u> , and that death occurred at <u>7:50</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.E. Byrkit</u>		M.D. <u>28 W Potomac</u>	
PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u>		ADDRESS (Street, city or town, state) <u>Williamsport Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 1-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Leitersburg Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Leitersburg Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport Md.</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>MAY 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hana</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





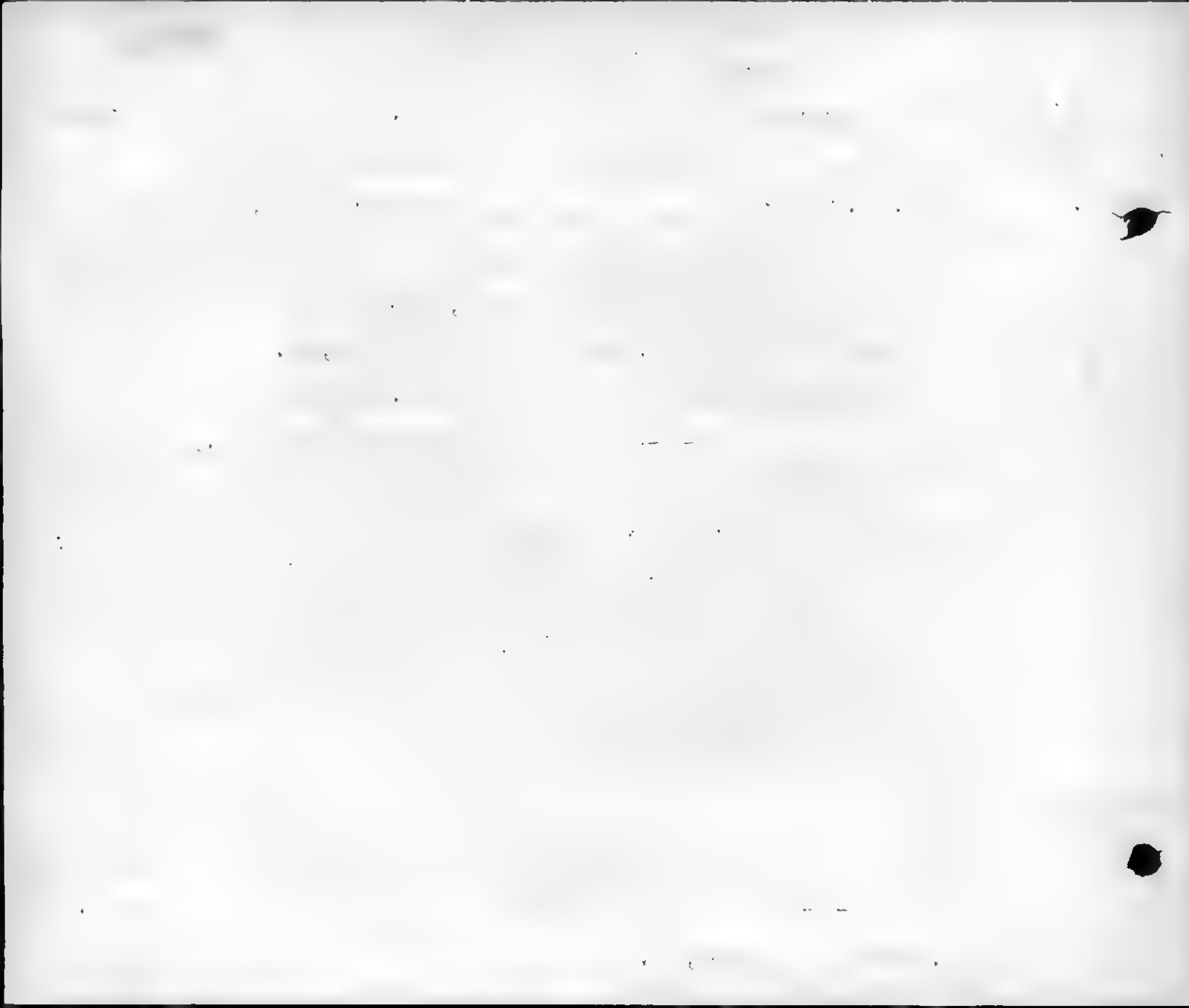
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

05068

5033

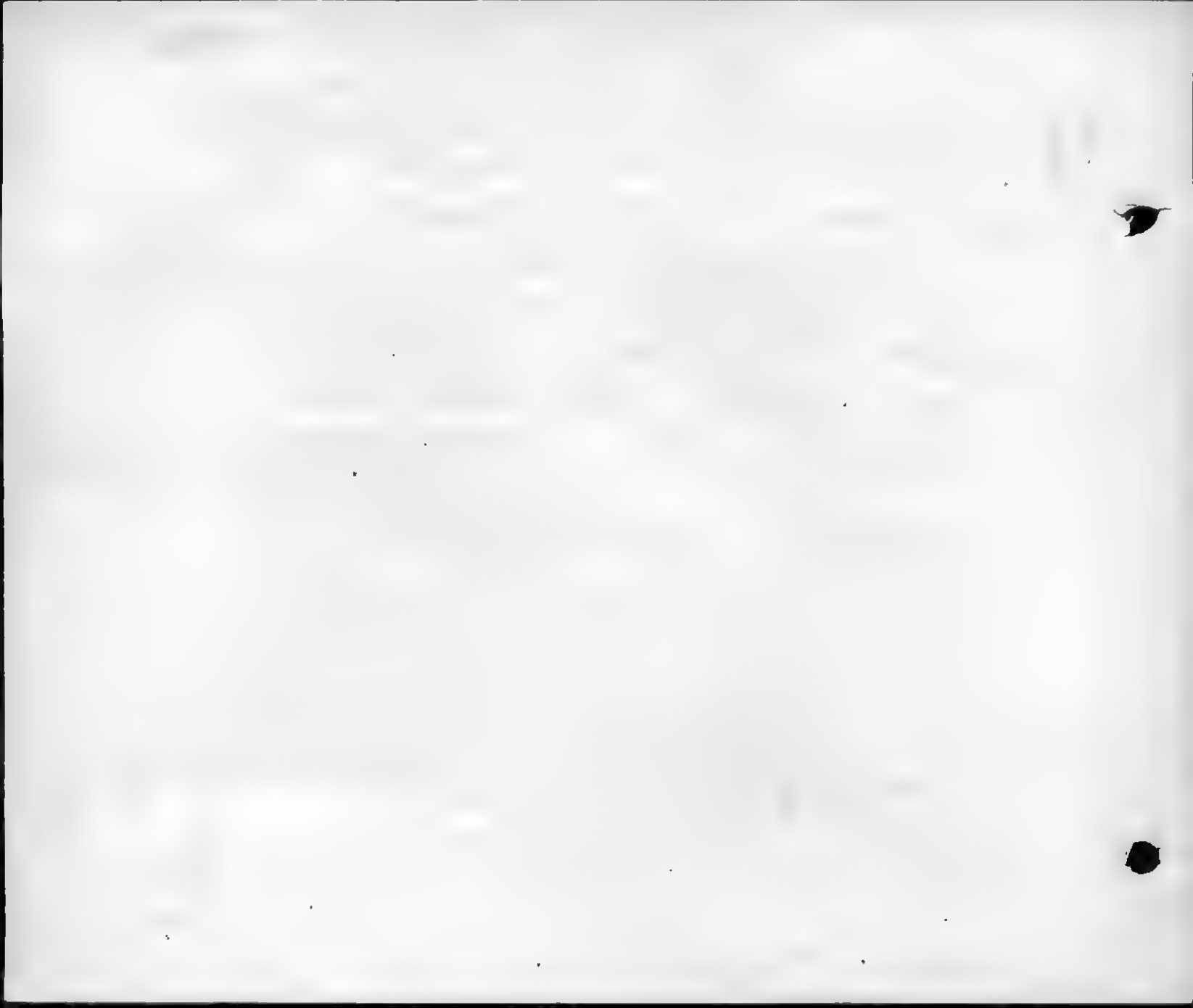
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>J</b> Middle <b>Howard</b> Last <b>McCune</b>		4. DATE OF DEATH Month <b>4</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 30, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printer</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Thomas McCune</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Atherton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-7827</b>	
17. INFORMANT <b>John McCune</b> Address <b>314 Radcliff Ave., City</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Complete heart block, recurrent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Posterior septal myocardial infarction</b> (c) <b>arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>Resolving left lower lobe pneumonia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19 <b>4/9</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/9</b> 19 <b>60</b> to <b>4/21</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4/20</b> 19 <b>60</b> , and that death occurred at <b>8AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John C. Stauffer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>4-23-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 25 '60</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	



1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 5034  
 CERTIFICATE OF DEATH

05069

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>6Wks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>816 Virginia Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOSEPH ELMER McDANIEL</b>				4. DATE OF DEATH Month Day Year <b>April 23 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 6, 1876</b>	
9. AGE (in years last birthday) <b>84</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		11. BIRTHPLACE (State or foreign country) <b>Everett Bedford Co., Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Willson W. McDaniel</b>				14. MOTHER'S MAIDEN NAME <b>Adeline Leader</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Mrs Vera H. McDaniel 816 Virginia Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 Wks</b> <b>1 year</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>14 May 58</b> to <b>24 April 1960</b> , that (I) (we) last saw the deceased alive on <b>23 April 1960</b> , and that death occurred at <b>11 PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Edwin S. Hoachlander M.D.</b>				22b. DATE SIGNED <b>4/25/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Edwin S. Hoachlander</b>				22d. ADDRESS <b>Hagerstown Md.</b>			
23a. BURIAL, CREMATATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/26/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				25a. REC'D BY REGISTRAR DATE <b>APR 28 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05070

5035

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>PA</u> b. COUNTY <u>Fulton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wayne</u> Middle <u>Woodford</u> Last <u>Mellott</u>				4. DATE OF DEATH Month <u>April</u> Day <u>26</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 12 1892</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		11. BIRTHPLACE (State or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anderson Mellott</u>				14. MOTHER'S MAIDEN NAME <u>Ida Mae Shives</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs Catherine Mellott Warfordburg Rd</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congestive heart failure</u> DUE TO (c) <u>Hypertensive heart disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 18, 1960</u> , to <u>April 26, 1960</u> , that I last saw the deceased alive on <u>April 26, 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John C. Stauffer</u>				M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-29-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Needmore Fulton Co, PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. Shives</u>				ADDRESS <u>Harrisonville Pa</u>		24a. REC'D BY REGISTRAR DATE <u>APR 28 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>John C. Stauffer</u>							



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R#2</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown R#2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>ARBENA</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1894</b>
9. AGE (In years lost birthday) <b>65</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Eccard, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hiram Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Susan Reese</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Thomas A. Miller R#2 Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arterio-sclerotic Heart D.</b> (c) <b>pericarditis mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>p. m.</b> <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7:48</b> , 19 <b>60</b> , to <b>April 16</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 16</b> , 19 <b>60</b> , and that death occurred at <b>8:45</b> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sidney Hoveston</b> M.D.		ADDRESS (Street, city or town, state) <b>Hagerstown Md</b>	
PHYSICIAN'S NAME (Type) <b>SIDNEY HOVENSTEIN</b>		DATE SIGNED <b>4-16-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>APR 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4-3-0



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

05072

5112

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Md RFD #1</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Downsville</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Orea</b> Last <b>Moats</b>		4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 11 1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>1</b>	11. IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Bakersville Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>Thomas A. Wolford</b>	
14. MOTHER'S MAIDEN NAME <b>Ann Elizabeth Baker</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Williamsport Md RFD #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Accidental suffocation</b> DUE TO <b>Day</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO <b></b> (c) <b></b> DUE TO <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/12/60</b> to <b>4/12/60</b> , that (I) (we) last saw the deceased alive on <b>4/12/60</b> , and that death occurred <b>on 4/12/60</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Joseph Young</b>		22b. ADDRESS <b>Williamsport Md</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph Young</b>		22d. ADDRESS <b>Williamsport Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>April 14-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Bakersville Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Thomas</b>		25. REC'D BY REGISTRAR <b>Arthur S. Thomas</b>	
26. ADDRESS <b>Williamsport Md</b>		27. DATE <b>APR 14 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

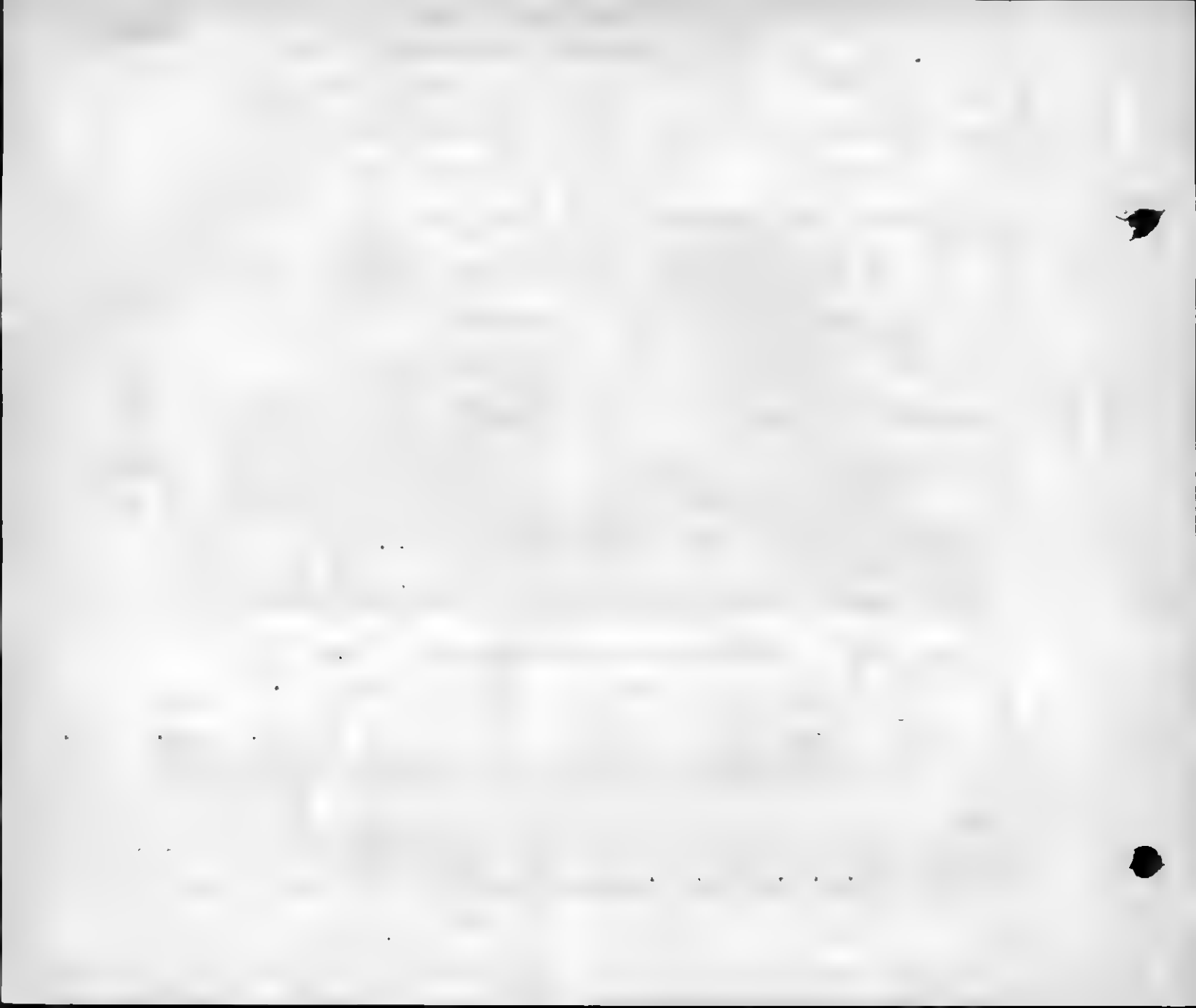
15073

5113

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPSBURG</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>BEAVER CREEK - RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ALONG ROUTE 34</u>		d. STREET ADDRESS <u>HAGERSTOWN MD. R. 1.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George McClelland Mowen</u>		4. DATE OF DEATH Month Day Year <u>APRIL - 17, 19 60</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 13, 1931</u>
9. AGE (In years last birthday) <u>28</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>7 4</u>	IF UNDER 24 HRS. <u>19 60</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER - POWERS AND SELLERS ABBITON.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FRANKLIN CO. PENNA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>MARVIN MOWEN</u>		14. MOTHER'S MAIDEN NAME <u>HAZEL STINE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>168-24-2611</u>	
17. INFORMANT <u>MRS. PATSY MOWEN HAGERSTOWN MD. R. 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Amputation Left Leg Above Knee.</u> DUE TO (c) <u>Fracture Right Humerus &amp; Femur</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Speeding car left road crashing into tree.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:47</u> p. m. <u>4-17-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R 7 34</u>		20f. (City or town) (County) (State) <u>Sharpsburg, Wash. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 22, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>HAGERSTOWN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. East</u>		24a. REC'D BY REGISTRAR <u>APR 22 '60</u>	
ADDRESS <u>BONNSBORO MD</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5036 CERTIFICATE OF DEATH

05074

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>D.</b> b. COUNTY <b>WASH.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAVERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>7 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASH. CO. HOSP.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAVERSTOWN</b>	
3 NAME OF DECEASED (Type or print) First <b>HERMAN</b> Middle <b>F.</b> Last <b>MUNSON</b>		4 DATE OF DEATH Month <b>4</b> Day <b>7</b> Year <b>1960</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>APRIL 15, 1881</b>
9 AGE (In years last birthday) <b>78</b> yrs		10 IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONTRACTOR</b>		10b KIND OF BUSINESS OR INDUSTRY <b>GEN CONTRACTING</b>	
11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>FREDERICK MUNSON</b>		14 MOTHER'S MAIDEN NAME <b>AMELIA SHAFER</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16 SOCIAL SECURITY NO <b>214-09-4919</b>	
17 INFORMANT <b>RS. STELLA MUNSON</b>		Address <b>LAVERSTOWN, D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Caecum</b> <b>153.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized metastases</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>1 mo.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus.</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12-13, 1957</b> to <b>4-7</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4-7</b> , 19 <b>60</b> , and that death occurred on <b>10<sup>th</sup></b> AM, from the causes and on the date stated above.			
22a SIGNATURE <b>Charles F. Hess</b>		22b DATE <b>4-9-60</b>	
22c PHYSICIAN'S NAME (Type) <b>Smithsburg, Md.</b>		22d ADDRESS	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>4/11/1960</b>	
23c NAME OF CEMETERY OR CREMATORY <b>ROSE HILL</b>		23d LOCATION (City, town, or county) (State) <b>LAVERSTOWN, D.</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>RED L. NAISS</b>		25a REC'D BY REGISTRAR DATE <b>APR 12 '60</b>	
ADDRESS <b>LAVERSTOWN, D.</b>		25b REGISTRAR'S SIGNATURE <b>Charles S. Hays</b>	



## 5112 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Ringgold</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b>	
c. LENGTH OF STAY IN 1b <b>2 Years</b>		d. STREET ADDRESS <b>140 S. Broad St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hagerstown #5</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Pauline</b> Last <b>Neady</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 9, 1891</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>	
11. BIRTHPLACE (State or foreign country) <b>Upton Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Neady</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Spielman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. S. Harold Martin, Waynesboro, Pa.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of colon with generalized metastases</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/15/1956</b> to <b>4/13/1960</b> , that I last saw the deceased alive on <b>4/13/1960</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 West Main Street Waynesboro, Pennsylvania</b> DATE SIGNED			
ACTUAL SIGNATURE <b>C. W. Lindeman</b> M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>C. W. Lindeman, M.D.</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/16/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter S. ...</b>		24a. REC'D BY REGISTRAR <b>DATE APR 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

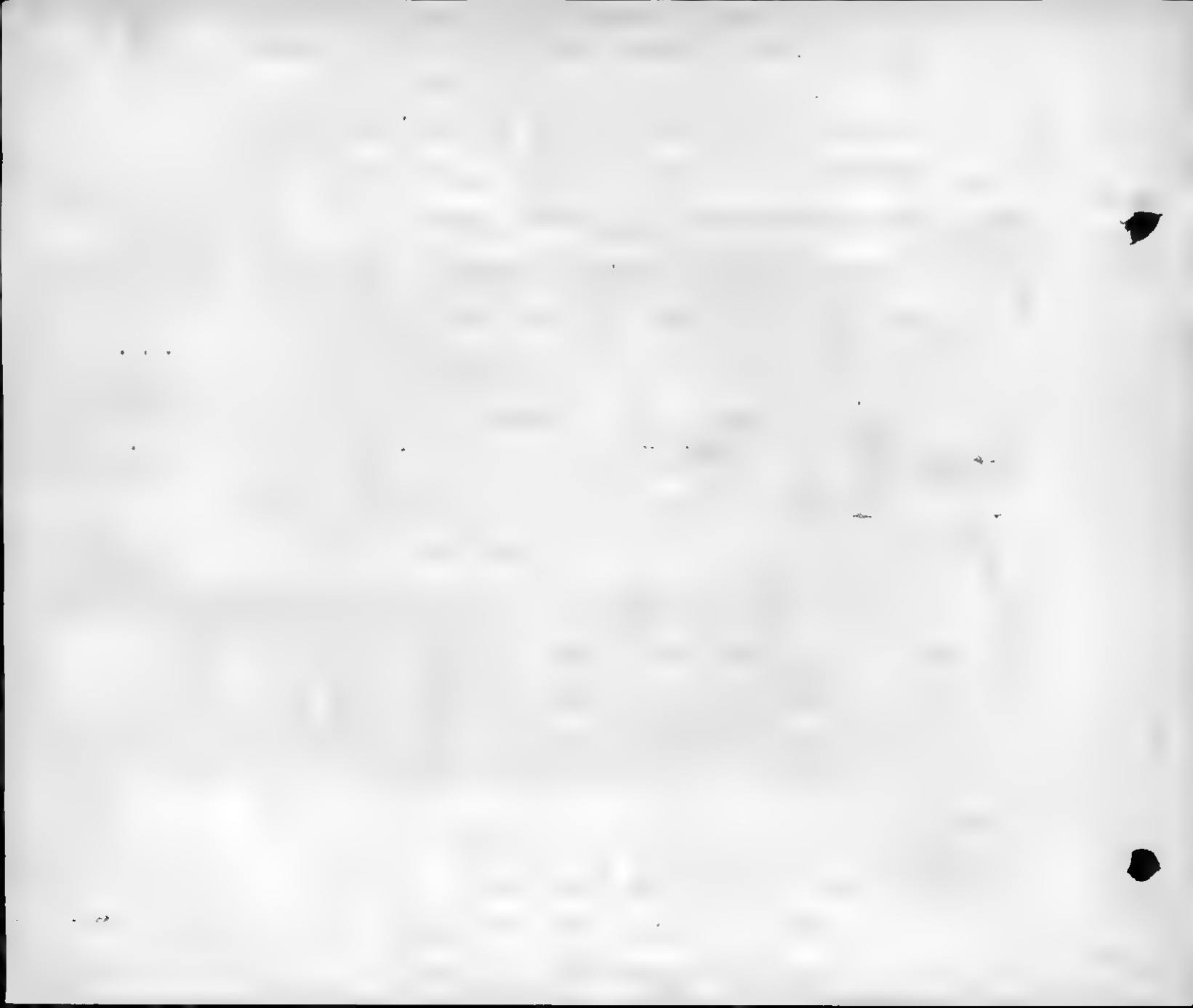
153.8



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00000**  
**5115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05076  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) e. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clear Spring Md.</b>			c. LENGTH OF STAY IN lb <b>10 Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charmian</b> 755		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>C.</b> Last <b>Niemyer</b>				4. DATE OF DEATH Month <b>6</b> Day <b>10</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/15/1897</b>	
				9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cost Accountant</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Funkhouser Plant</b>		11. BIRTHPLACE (State or foreign country) <b>Green Spring Furnace Md.</b>	
13. FATHER'S NAME <b>William G. Niemyer</b>				14. MOTHER'S MAIDEN NAME <b>Myrtie Tedrick</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>214-09-1337</b>		17. INFORMANT <b>Mrs. Paul C. Niemyer, Charmian, Pa.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerotic Heart Disease</b> DUE TO (c) <b>2 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>DREW H. TITTO</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>DREW H. TITTO</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/12/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Clear Spring, Washington Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Waynesboro Pa.</b>				24a. REC'D BY REGISTRAR DATE <b>APR 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hume</b>	

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in item 18. Give Pages 2, 3, and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65077

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MD b. COUNTY WASH.	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 4 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRCHILD AIRCRAFT PLANT I		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING	
3. NAME OF DECEASED (Type or print) First Middle Last VIRGIL B. PECK		4. DATE OF DEATH Month Day Year 4 21 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT 15, 1904
9. AGE (In years and birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOBE PECK		14. MOTHER'S MAIDEN NAME NORA SUFFECOL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-09-9297	
17. INFORMANT MRS. JAMES COYLE		Address BOONSPORO, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 120.0 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) General arteriosclerosis & (c) arteriosclerotic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Terminal		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Edward W. Ditto III, M. D.		DATE SIGNED 4/22/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/23/1960	
22c. NAME OF CEMETERY OR CREMATORY BLAIRS VALLEY		22d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. CLARK		24a. REC'D BY REGISTRAR DATE APR 25 '60	
ADDRESS CLEAR SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

65078

CERTIFICATE OF DEATH

5033

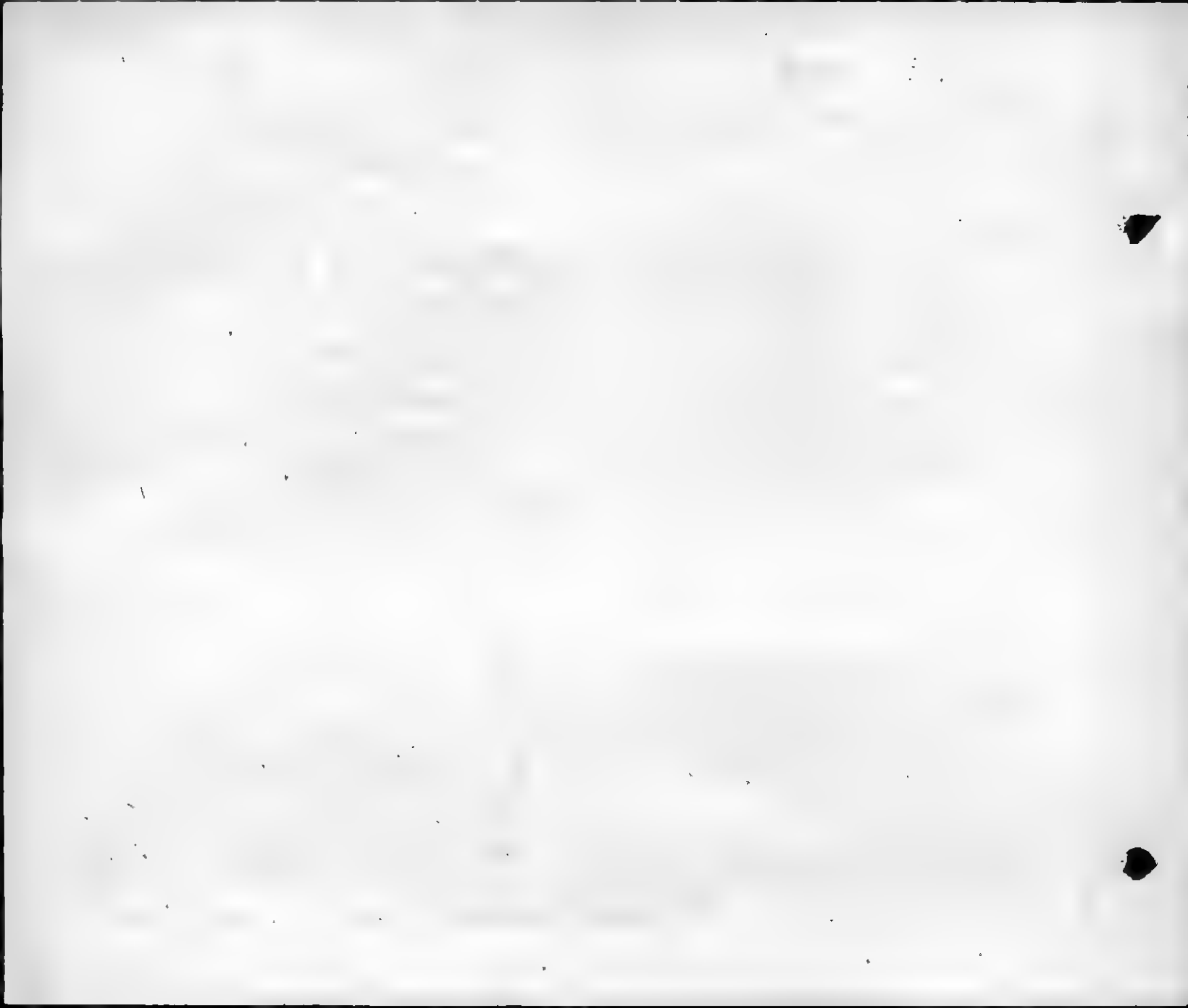
Item 2 Film 6201

4/29/60 iwl

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>6 Weeks</b> d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Wash Counth Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Downsville</b> Res. <b>Cumberland, Ma.</b> d. STREET ADDRESS <b>Weburn Conv Home</b> IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>EDWARD</b> Last <b>PITSNOGLE</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 3 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b>	11. IF UNDER 24 HRS. Hours <b>75</b> Min. <b>75</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Pitsnogle</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Weaver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>320-10-2010</b>	
17. INFORMANT Address <b>Mrs Gertrude Wise 21 E. Baltimore St</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic</b> <b>420.1</b> DUE TO <b>infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Myocardial</b> DUE TO <b>infarction</b> (c) <b>Myocardial</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/5/60</b> to <b>4/6/60</b> , that (I) (we) last saw the deceased alive on <b>4/6/60</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above			
22a. SIGNATURE <b>Calvin Young</b>		22b. DATE SIGNED <b>4/7/60</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Williamport Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Cumberland Allegany Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>APR 11 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

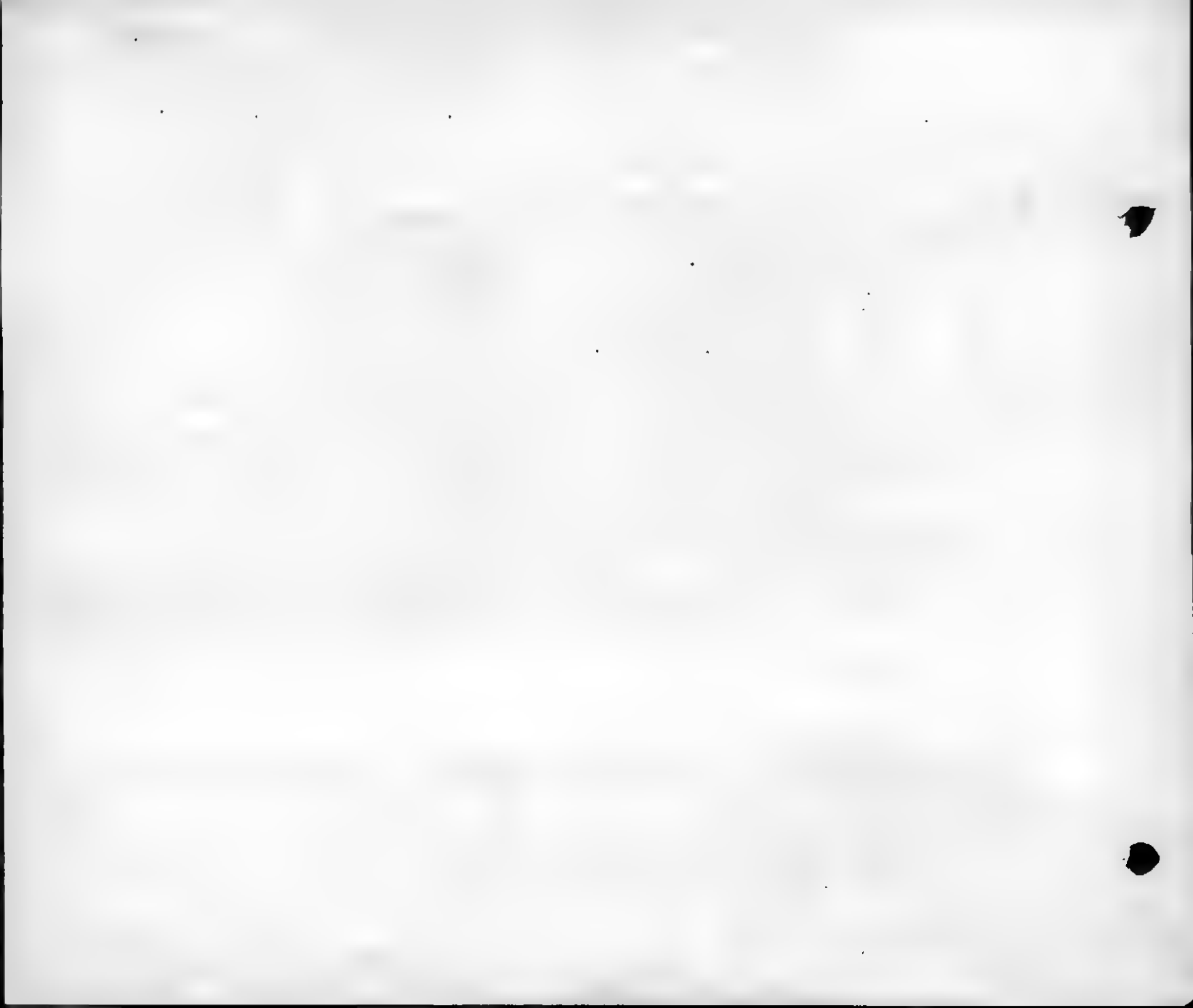
5035

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65079

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WILLIAMSPORT</u>				c. LENGTH OF STAY IN 1b <u>10mo. 28 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WILLIAMSPORT SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD ELLSWORTH POFFENBERGER</u>				4. DATE OF DEATH Month Day Year <u>APRIL - 29 - 1960</u>			
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-5-1873</u>	9. AGE (In years lost birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM.</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR KEEDYSVILLE MD U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SAMUEL POFFENBERGER</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE DOUB</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>THEODORE POFFENBERGER KEEDYSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> 120.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>arteriosclerotic heart</u>						INTERVAL BETWEEN ONSET AND DEATH <u>yes.</u> <u>yes.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Louis G. Gratt</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Louis G. Gratt</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY-2-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>BOONSBORO WASH. CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 5 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>	

✓







440X

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

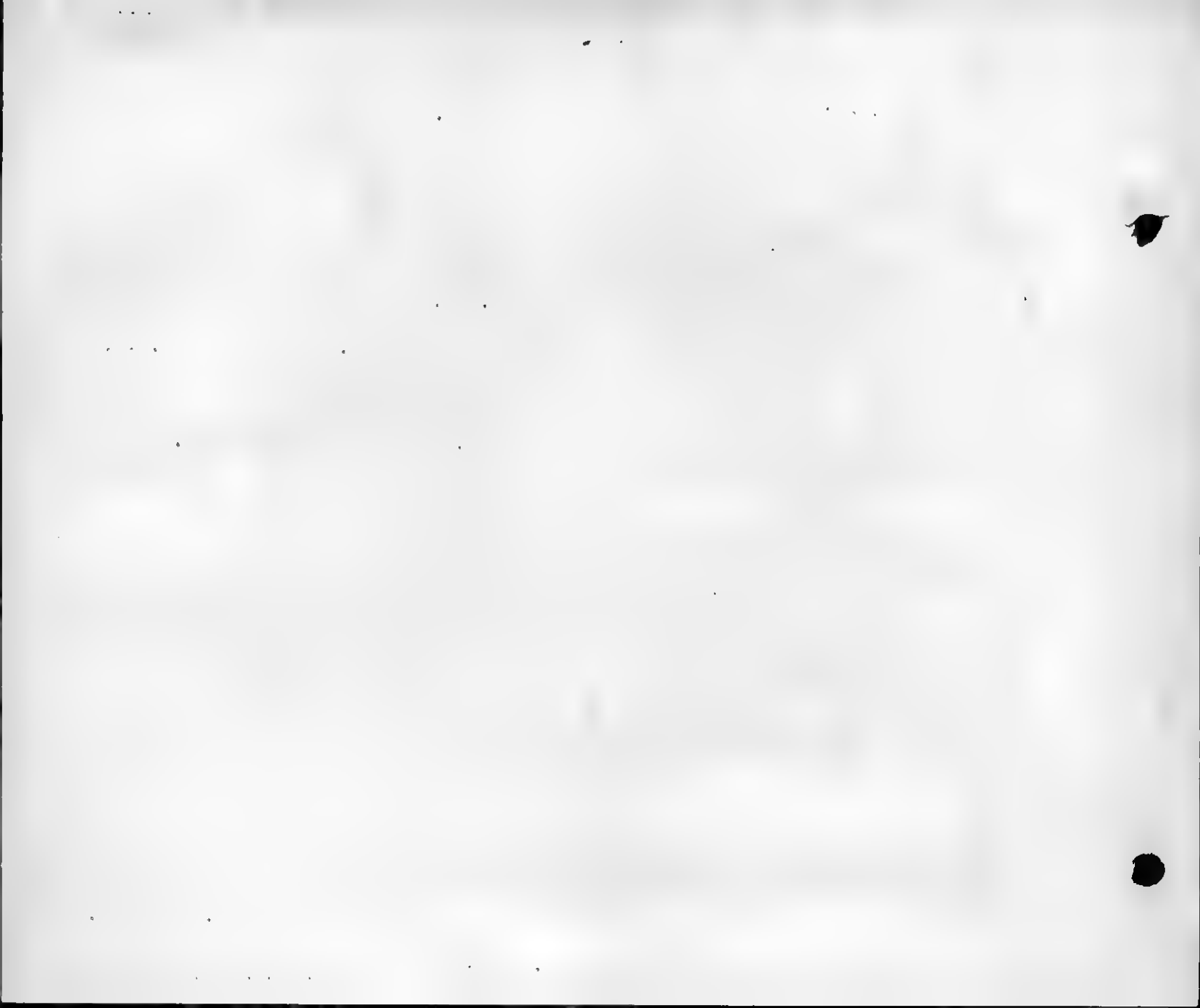
5116

## CERTIFICATE OF DEATH

Reg. Dist. No. **05081**

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cascade</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cascade</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edith</b> Middle <b>Grace</b> Last <b>Pryor</b>		4. DATE OF DEATH Month <b>April</b> Day <b>9</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1896</b>
9. AGE (In years last birthday) <b>63</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Duties</b>	
11. BIRTHPLACE (State or foreign country) <b>Cascade, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Moser</b>		14. MOTHER'S MAIDEN NAME <b>Susan Nichols</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Calvin G. Pryor Sr., Cascade Md.</b>	
17. INFORMANT <b>Calvin G. Pryor Sr., Cascade Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan</b> , 19 <b>48</b> , to <b>April 9</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>April 9</b> , 19 <b>60</b> , and that death occurred at <b>6:30</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Thompson</b>		ADDRESS (Street, city or town, state) <b>Blue Ridge Summit, Pa.</b> DATE SIGNED <b>10 April 60</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/12/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>	22d. LOCATION (City, town, or county) (State) <b>Lantz #1, Fred. Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Y. Lowe</b>		ADDRESS <b>Waynesboro, Pa.</b>	
24a. REC'D BY REGISTRAR <b>APR 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO TOMB DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

65082

5040

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASH</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wash</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown RT# 6</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JENNIE</b> Middle <b>W.</b> Last <b>PRYOR</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1887 1867 Feb. 8</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>nothing</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick County Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joel Willard</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Howard Schilling, Hagerstown, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> DUE TO (b) <b>Arteriosclerosis Generalized</b> DUE TO (c) <b>Cerebral Vascular hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>yrs.</b> <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psoriasis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19 53</b> to <b>April 13 19 60</b> , that I last saw the deceased alive on <b>April 13, 1960</b> , and that death occurred at <b>6:45 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>4-13-60</b>	
ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Louis G. Graff, M.D.</b>		<b>119 E. Antietam St. Hagerstown</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/16/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>	22d. LOCATION (City, town, or county) (State) <b>Lantz Md. R.D.1</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Waynesboro, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 18 60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

331 +

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5041

## CERTIFICATE OF DEATH

65083

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARTIN MANOR REST HOME 1222 Virginia Ave.,</b>				d. STREET ADDRESS <b>Saint Paul's</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LUELLA</b> Middle <b>WHITE</b> Last <b>PRYOR</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>FEBRUARY 7 1884</b>	
9. AGE (In years last birthday) <b>76 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Public Schools</b>		11. BIRTHPLACE (State or foreign country) <b>EMMITSBURG, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>WALTER W. WHITE</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE ROWE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>Mrs. Earl Knepper, Clear Spring, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CHRONIC NEPHRITIS</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>UNKNOWN</b>				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 26, 1960</b> to <b>April 15, 1960</b> , that I last saw the deceased alive on <b>April 14, 1960</b> , and that death occurred at <b>5:30 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.							
PHYSICIAN'S NAME (Type) <b>Archie Robert Cohen, M.D.</b>				<b>Clear Spring, Maryland</b>		<b>April 15, 1960</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/18/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. E. Wilson</i> <b>C. E. Wilson</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hearn</i>			

4.00



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65084

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Hook		c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sandy Hook			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Own Residence				d. STREET ADDRESS 101 Old U.S. 340		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle PEARL Last RAY				4. DATE OF DEATH Month April Day 6, Year 19 60			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1881		9. AGE (In years last birthday) 78 yrs.	10. UNDER 1 YEAR Months Days Hours Min.	11. UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Tom's Brook, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James William Ray				14. MOTHER'S MAIDEN NAME Marian Dawson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None 212-24-5835		17. INFORMANT Mrs. Melvin O. Address Hoar 712 B. St., Brunswick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiac Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 yrs?							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE J. E. W. D. T. O. 2				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/60		22c. NAME OF CEMETERY OR CREMATORY Virts Cemetery		22d. LOCATION (City, town, or county) (State) Sandy Hook, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Eckler				ADDRESS Harpers Ferry, W.V.		24a. REC'D BY REGISTRAR DATE APR 11 1960	
				24b. REGISTRAR'S SIGNATURE C. L. H. H. H.			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse it. This certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

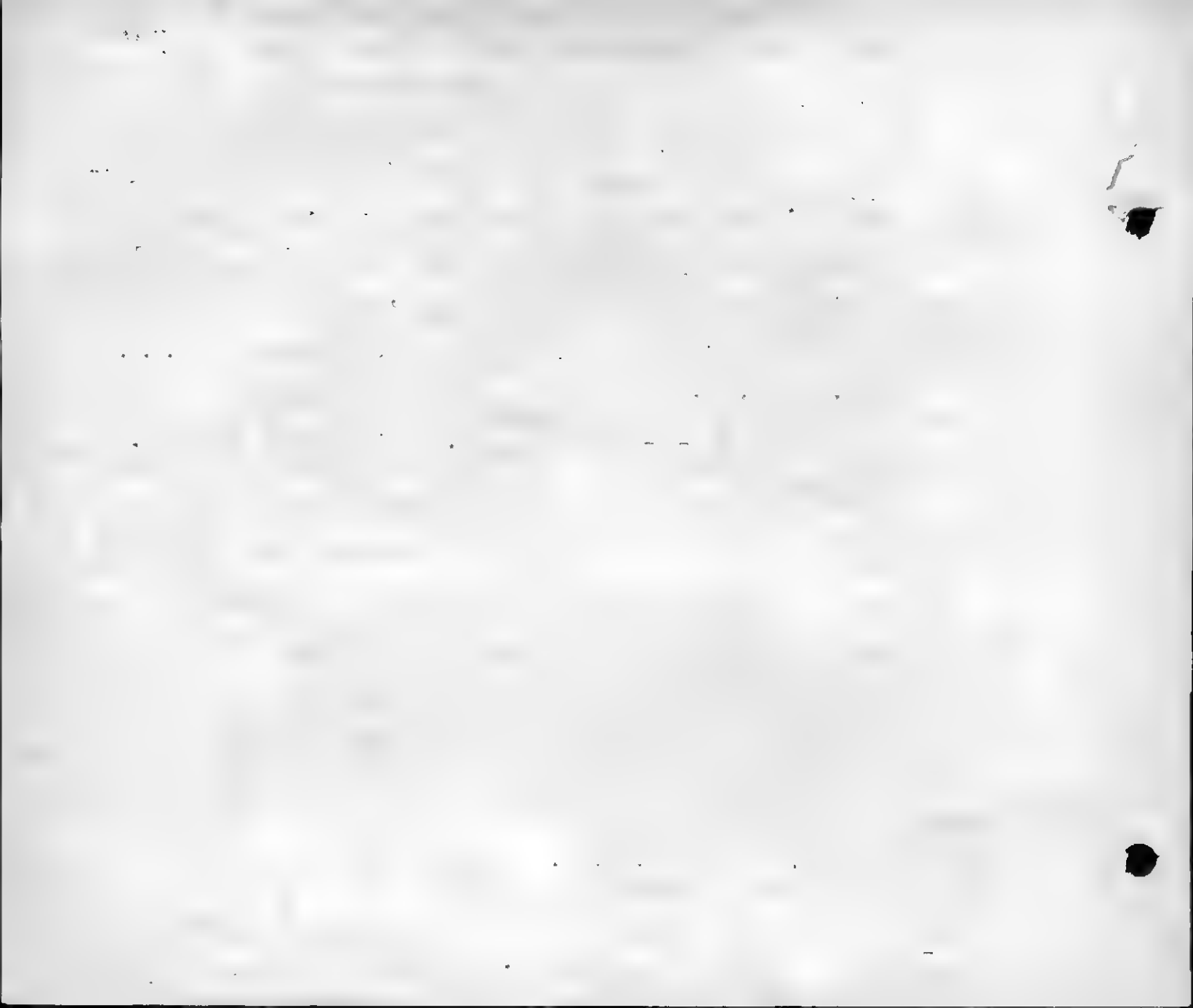
VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5042 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN life <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>704 Oak Hill Ave.</u>				d. STREET ADDRESS <u>704 Oak Hill Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLMOUTH</u> Middle <u>SALOME</u> Last <u>REININGER</u>				4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>19 60</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 19, 1909</u>		9. AGE (In years last birthday) <u>50 yrs.</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Witmer, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Ethel May Draper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-1074</u>		17. INFORMANT Address <u>Edward F. Reininger Hagerstown, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive subarachnoid hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to vascular anomaly</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Edward W. Ditto</u> , M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4/23/60</u>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/23/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter - Rouzer Funeral Home</u> <u>R. Franklin Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hound</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)  
ISM 9/59

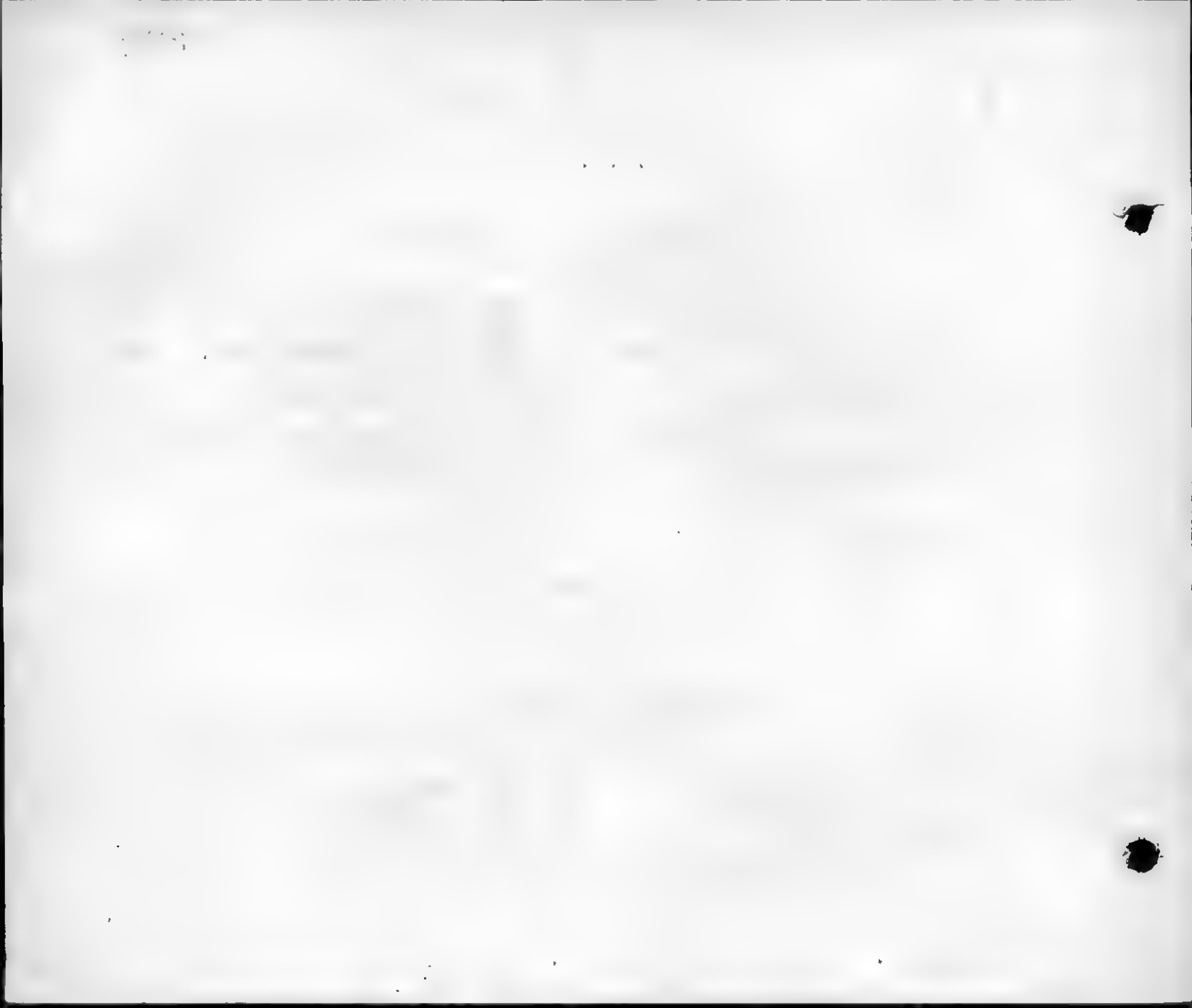
5043

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

302

65086

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport R # 1</b> d. STREET ADDRESS <b>Downsville</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ANNA ELEANOR ROHRER</b>		4. DATE OF DEATH Month Day Year <b>April 15 1960 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 24 1886</b> 9. AGE (In years last birthday) <b>73 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Hollyday</b>		14. MOTHER'S MAIDEN NAME <b>Alice Talbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Mrs Alice Downey Williamsport R # 1</b>		Address <b>Downsville</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 720.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Atherosclerosis</b> DUE TO (c) <b>Atherosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1948</b> to <b>April 10, 1960</b> , that (I) (we) last saw the deceased alive on <b>April 12, 1960</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>B B Kneisley</b>		22b. DATE <b>April 10 1960</b>	
22c. PHYSICIAN'S NAME (Type) <b>B B KNEISLEY</b>		22d. ADDRESS <b>148 W. Washington St. Hagerstown Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Sharpsburg Wash Co Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>APR 20 '60</b>	
ADDRESS <b>Hagerstown Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>	



65087  
Reg. Dist. No.

5118

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>Franklin</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Cascade</b>		c. LENGTH OF STAY IN Ib <b>6 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waynesboro</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hawn Conv. Home</b>			d. STREET ADDRESS <b>415 S. Potomac St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>Viola</b> Last <b>Rossman</b>			4. DATE OF DEATH Month <b>April</b> Day <b>15</b> Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/30/1900</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Venton, Pa.</b>	
13. FATHER'S NAME <b>Charles Belles</b>			14. MOTHER'S MAIDEN NAME <b>Ruth Hummel</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Walter F. Rossman, 415 S. Pot. St., Waynesboro</b> Address <b>Pa.</b>	

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decomposition</u> 4344 DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. } (b) _____ DUE TO (c) _____		

CATION	PART II. OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

MEDICAL CERTIFICATE	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)					
	20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		

21. I certify that I attended the deceased from 12 April, 1960, to 15 April, 1960, that I last saw the deceased alive on 14 April, 1960, and that death occurred at 3:45 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

ACTUAL Robert A. Kiefer M.D. Blue Ridge Summit, Pa. 15 April 60  
SIGNATURE

PHYSICIAN'S NAME (Type) Robert A. Kiefer Blue Ridge Summit Pa.

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Shrine</b>	22d. LOCATION (City, town, or county) <b>Franklin Township, Luzerne Co. Pa.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Hoane</i>		ADDRESS <i>1400 N. 1st St. Hazleton, Pa.</i>	24a. REC'D BY REGISTRAR DATE <b>APR 18 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hoane</i>

VS A15 (4)  
15M 10/57

434.4



## CERTIFICATE OF DEATH

65088  
Reg. Dist. No.

5044

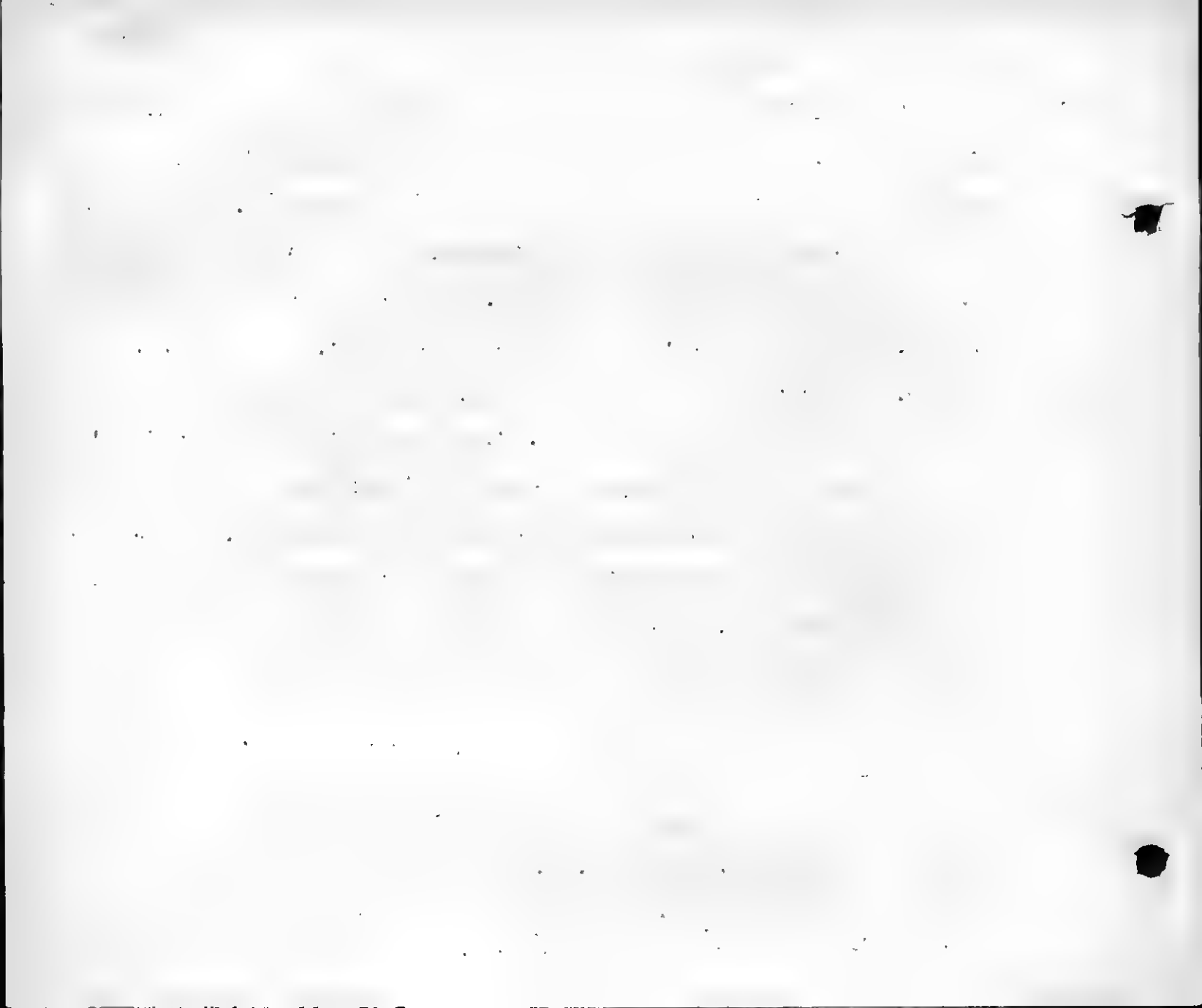
1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN lb <b>20 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Estella Eliza Roulette</b>		4. DATE OF DEATH Month Day Year <b>April 21 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6 1884</b>
9. AGE (In years last birthday) yrs <b>75</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min. <b>4 14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>John D. Rensburg</b>		14. MOTHER'S MAIDEN NAME <b>Emma Hagerman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> No		16. SOCIAL SECURITY NO. <b>219 36 2603</b>	
17. INFORMANT <b>Mr. Paul Roulette</b>		Address <b>Sharpsburg Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolus &amp; infarction</b> 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Postoperative emboli from deep pelvic veins 1 week</b> DUE TO (c) <b>Gastrectomy for bleeding stomach ulcer 2 weeks</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe paralytic ileus</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Sharpsburg, Md.</b>	
21. I certify that I attended the deceased from <b>April 2, 1960</b> to <b>April 21, 1960</b> , that I last saw the deceased alive on <b>April 20, 1960</b> , and that death occurred at <b>2:40 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b> DATE SIGNED <b>4/22/60</b> ACTUAL SIGNATURE <b>Walter H. Shealy</b> M.D. PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>			
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 23-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharpsburg Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert L. Legg</b>		24a. REC'D BY REGISTRAR <b>APR 25 1960</b>	
ADDRESS <b>Williamsport Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hodge</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



5045

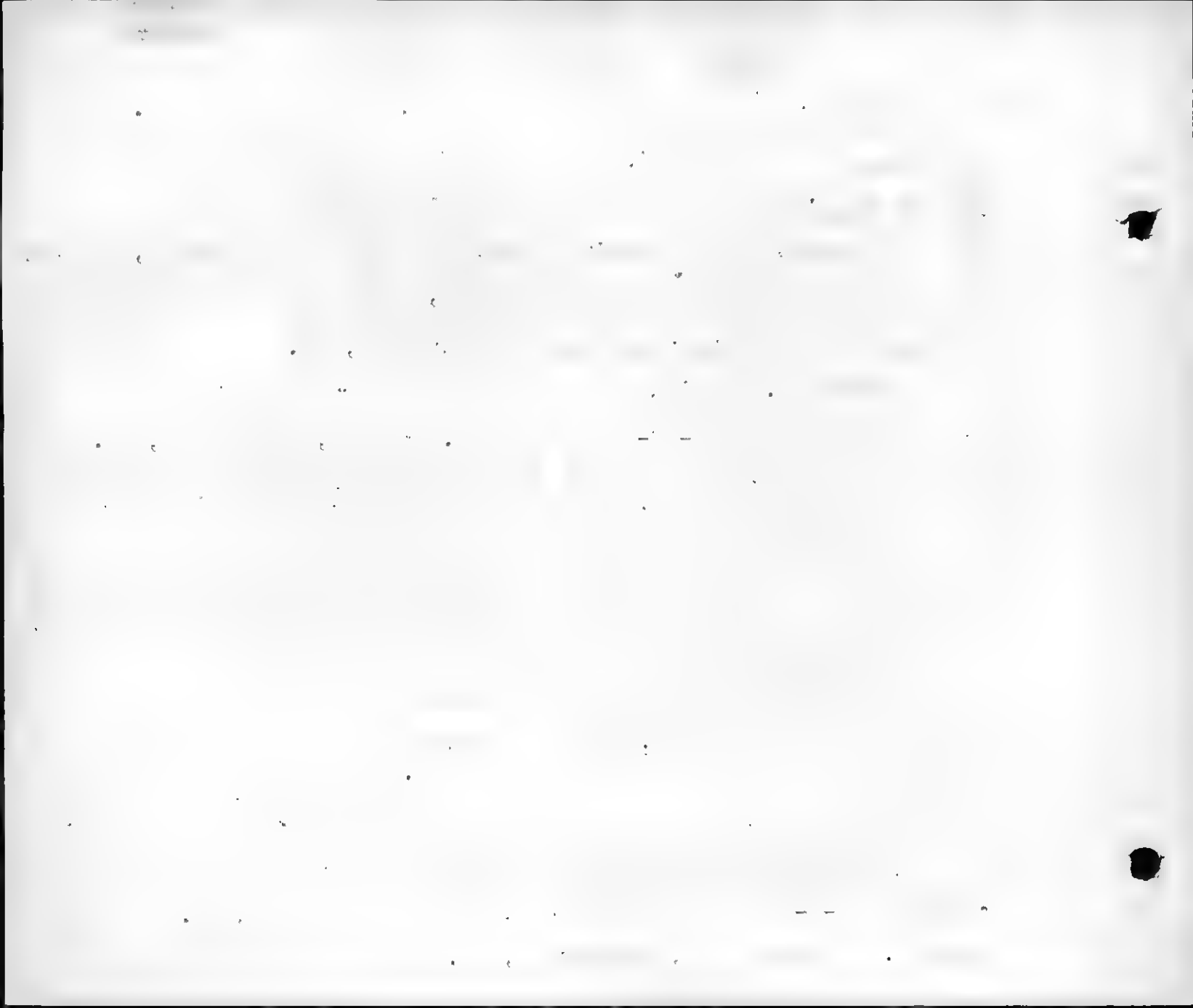
## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
c. LENGTH OF STAY IN life <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>395 Key Circle</b>		d. STREET ADDRESS <b>395 Key Circle</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Frances</b> Middle <b>Catherine</b> Last <b>Shannon</b>		4. DATE OF DEATH Month <b>April</b> Day <b>6</b> Year <b>1960</b>	
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1909</b>
9 AGE (In years last birthday) <b>51</b>		10. IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>looper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>knitting mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b></b>	
13. FATHER'S NAME <b>George H. Wellinger</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Manious</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-4216</b>	
17. INFORMANT <b>James G. Shannon, Hagerstown, Md.</b>		Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of R. Breast with generalized metastasis</b> 170X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour <b></b> o. m. <b></b> p. m. <b></b> 19 <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I attended the deceased from <b>Oct 1954</b> to <b>6 Apr 1960</b> that I last saw the deceased alive on <b>6 Apr 1960</b> , and that death occurred at <b>1945 W. 230th St</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. F. Lusby</b>		DATE SIGNED <b>7 Apr 60</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>		<b>Hagerstown</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4-9-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>APR 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

65090

5046

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>76 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>EDGAR</b> Last <b>SINN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>14</b> Year <b>1960</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 10, 1880</b>	
9. AGE (In years last birthday) <b>79 yrs</b>		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b> Hours <b>14</b> Min.		11. IF UNDER 24 HRS. Months <b>7</b> Days <b>14</b> Hours <b>14</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Harrisburg, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Sinn</b>				14. MOTHER'S MAIDEN NAME <b>Ida Clark</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-28-6156</b>		17. INFORMANT <b>Rex Sinn</b> Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> <b>572.1</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Perforated Diverticulum of sigmoid</b> DUE TO (c) <b>Arteriosclerotic Heart Disease; Carcinoma of sigmoid</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A TUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from <b>April 11, 1960</b> to <b>April 14, 1960</b> that (I) (we) saw the deceased alive on <b>April 14, 1960</b> , and that death occurred at <b>8:40 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>W. T. Layman</i>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>W. T. Layman, M.D.</b>				22d. ADDRESS <b>100 Professional Arts Bldg. Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Franklin Boyer</i>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE APR 18 '60</b>	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

2000

10/10/00

10/10/00



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

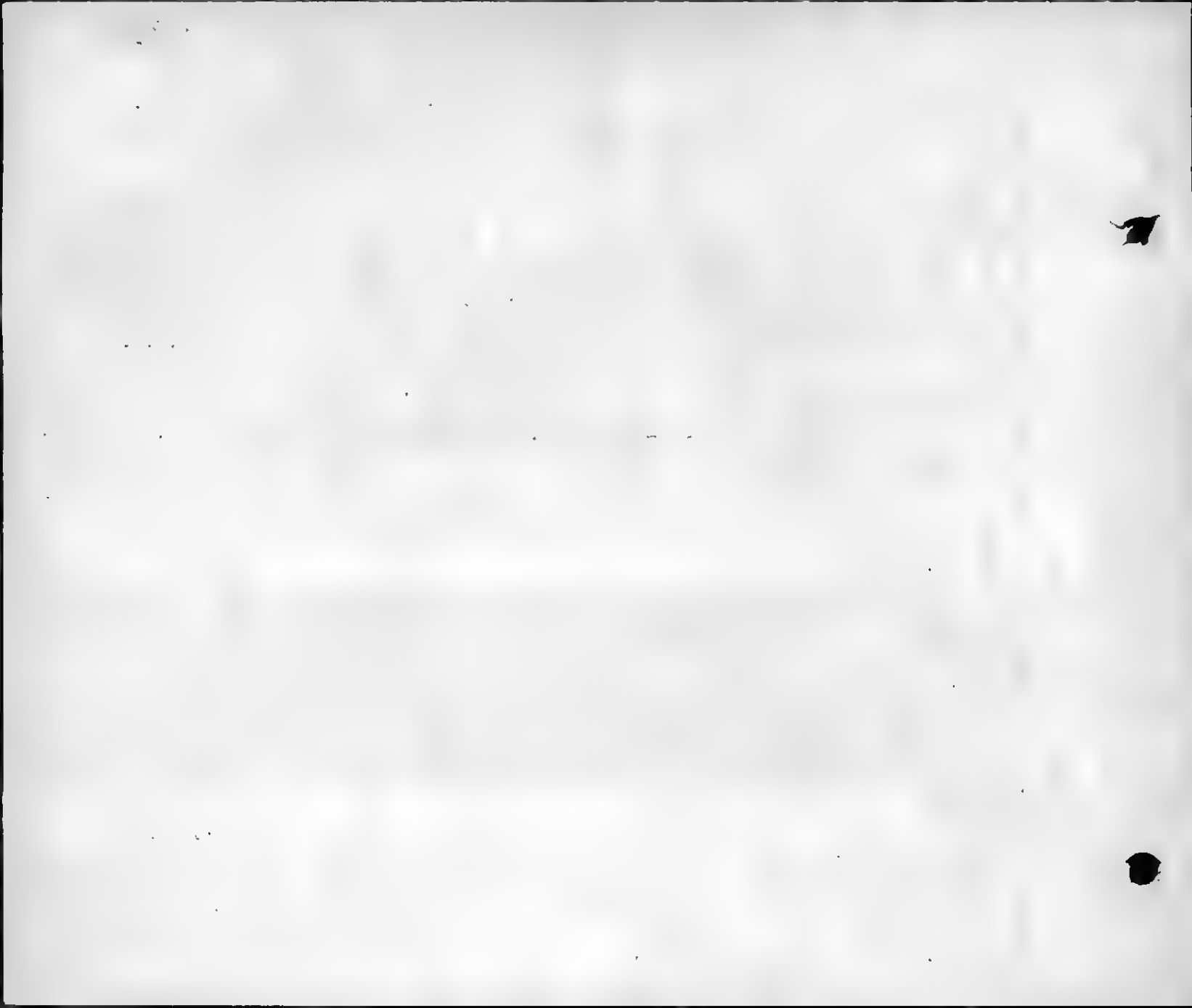
65091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING</b> c. LENGTH OF STAY IN 1b <b>38 YEARS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MUMMERT ROAD</b>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WASH.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CLEAR SPRING</b> d. STREET ADDRESS <b>MUMMERT ROAD</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>BLAINE</b> Last <b>SITES</b>			4. DATE OF DEATH Month <b>4</b> Day <b>14</b> Year <b>1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 13, 1889</b>	9. AGE (In years and months) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>GEORGE F. SITES</b>		
14. MOTHER'S MAIDEN NAME <b>ALBERTA K. STULTZ</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>220-30-9227A</b>			17. INFORMANT <b>MRS. ELIZABETH SITES</b> Address <b>CLEAR SPRING, RT 2, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4:00 P.M. Sudden Ischemic Heart Disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>4:00</b> a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/13/60</b>	
EXAMINER'S NAME (Type) <b>D. E. W. C. T. T. O. J.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>4/16/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL</b>	22d. LOCATION (City, town, or county) <b>CLEAR SPRING, MD.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. CLARK</b> ADDRESS <b>CLEAR SPRING, MD.</b>			24a. REC'D BY REGISTRAR DATE <b>APR 19 '60</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain in writing. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





# DEPARTMENT OF HEALTH

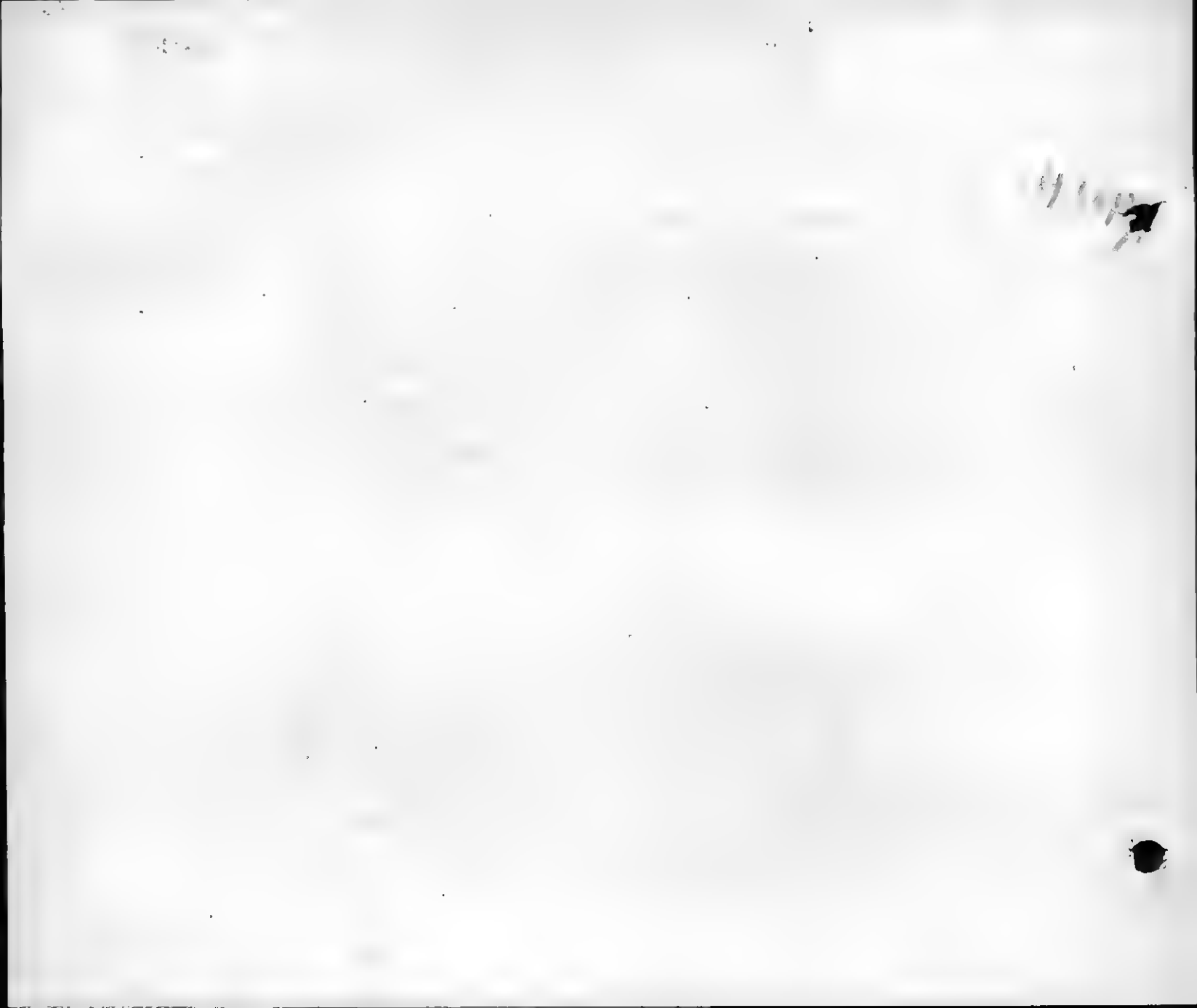
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

5043

65092

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>ONE WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> First <u>ELLA</u> Middle <u>M.</u> Last <u>SMITH</u>				<b>4. DATE OF DEATH</b> Month <u>APRIL</u> Day <u>20</u> Year <u>1960</u>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>OCT. 26 - 1902</u>	
<b>9. AGE</b> (In years lost birthday) <u>57</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>WEAVER - MARYLAND RIBBON CO.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>WASH. CO. MD. U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>WILLIAM YOST</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>HATTIE YOST</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>320-18-3034</u>		<b>17. INFORMANT</b> <u>MRS. HELEN MASER BOONSBORO MD. R. 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>633X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pan. hysterectomy</u> (c) <u>Thrombo-phlebitis femoral &amp; pelvic veins</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>5-6 days</u> <u>9 days</u> <u>5-6 days</u>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
				<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>April 17, 1960</u> <b>to</b> <u>Apr. 20, 1960</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Apr. 19, 1960</u> <b>and that death occurred at</b> <u>8 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>R. S. Stauffer</u>				<b>22b. DATE SIGNED</b> <u>Apr. 22, 1960</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>R. S. STAUFFER</u>				<b>22d. ADDRESS</b> <u>Hagerstown, Md.</u>			
<b>23a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>APR. 23, 1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. LENA CEMETERY</u>		<b>23d. LOCATION (City, town, or county)</b> <b>(State)</b> <u>MT. LENA WASH. CO. MD.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Vost</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Boonsboro MD.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Krane</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

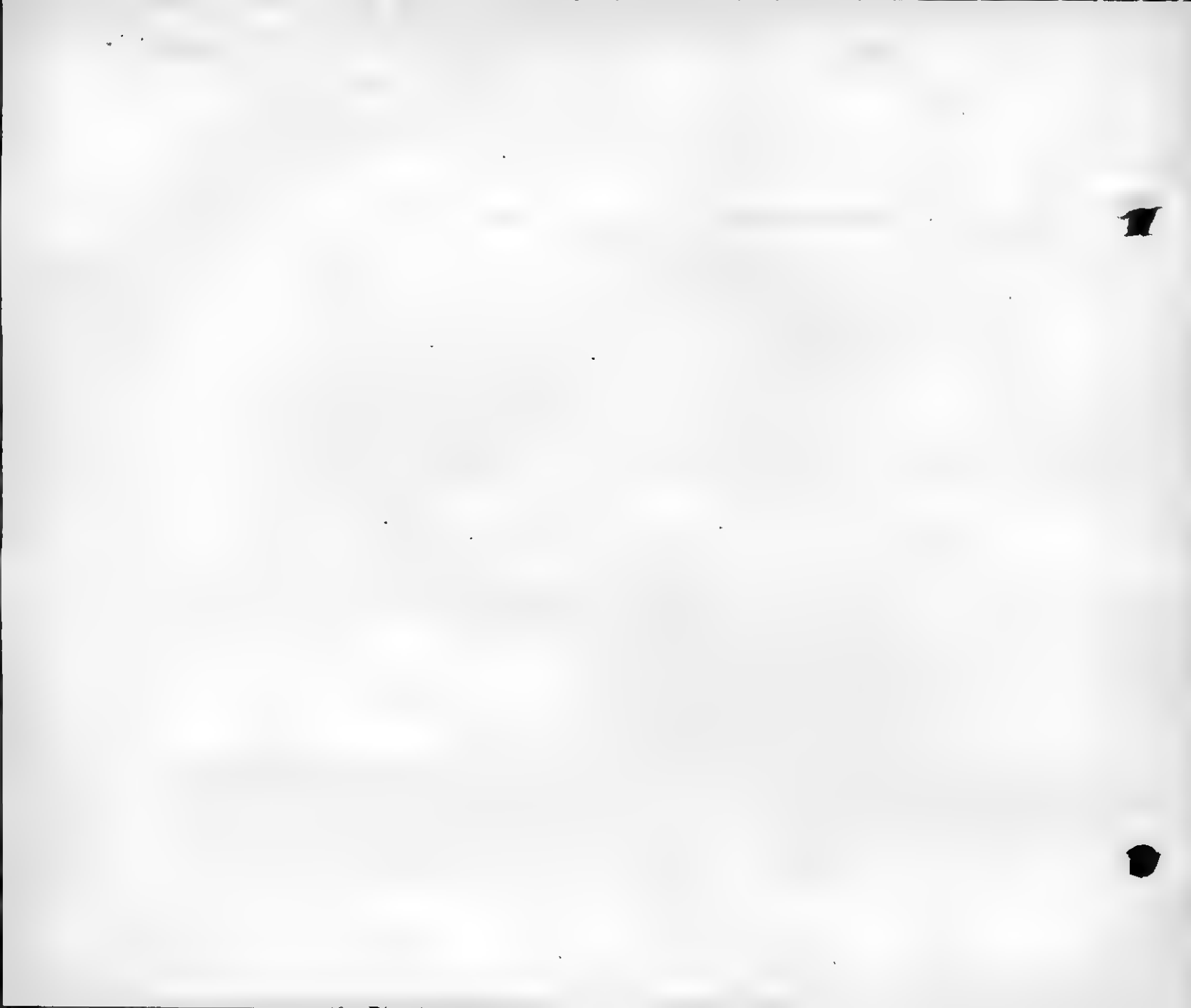
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ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5001

65093

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>		c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LOCUST GROVE, RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>FEEDER NURSING HOME</u>				d. STREET ADDRESS <u>ROHREKERSVILLE MD. R.1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE EDNA SMITH</u>				4. DATE OF DEATH Month <u>APRIL</u> - Day <u>3</u> - Year <u>1960</u>			
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY-29-1877</u>		9 AGE (In years lost birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LOCUST GROVE WASH. CO. MD. U.S.A</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ALBERT SMITH</u>				14. MOTHER'S MAIDEN NAME <u>SARAH GRIMM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17 INFORMANT Address <u>MRS. AXEL STEEL ROHREKERSVILLE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIO-SCLEROSIS</u> 4. DUE TO <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PURULENT CISTITIS</u>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Oct 6, 1950</u> to <u>April 3, 1960</u> , that (I) (we) last saw the deceased alive on <u>4-2-1960</u> , and that death occurred <u>at 4:30 PM</u> from the causes and on the date stated above.							
22a SIGNATURE <u>Joseph Secundari</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>April 4, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph Secundari, M. D.</u>				22d. ADDRESS <u>21 North Main St. Boonsboro, Maryland</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>APRIL-6-1960</u>		23c NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u>		23d LOCATION (City, town, or county) (State) <u>LOCUST GROVE WASH. CO. MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. East</u>				ADDRESS <u>BOONSBORO MD</u>		25d. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>	
				25b REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>			



FOR STATE  
HEALTH DEPT.

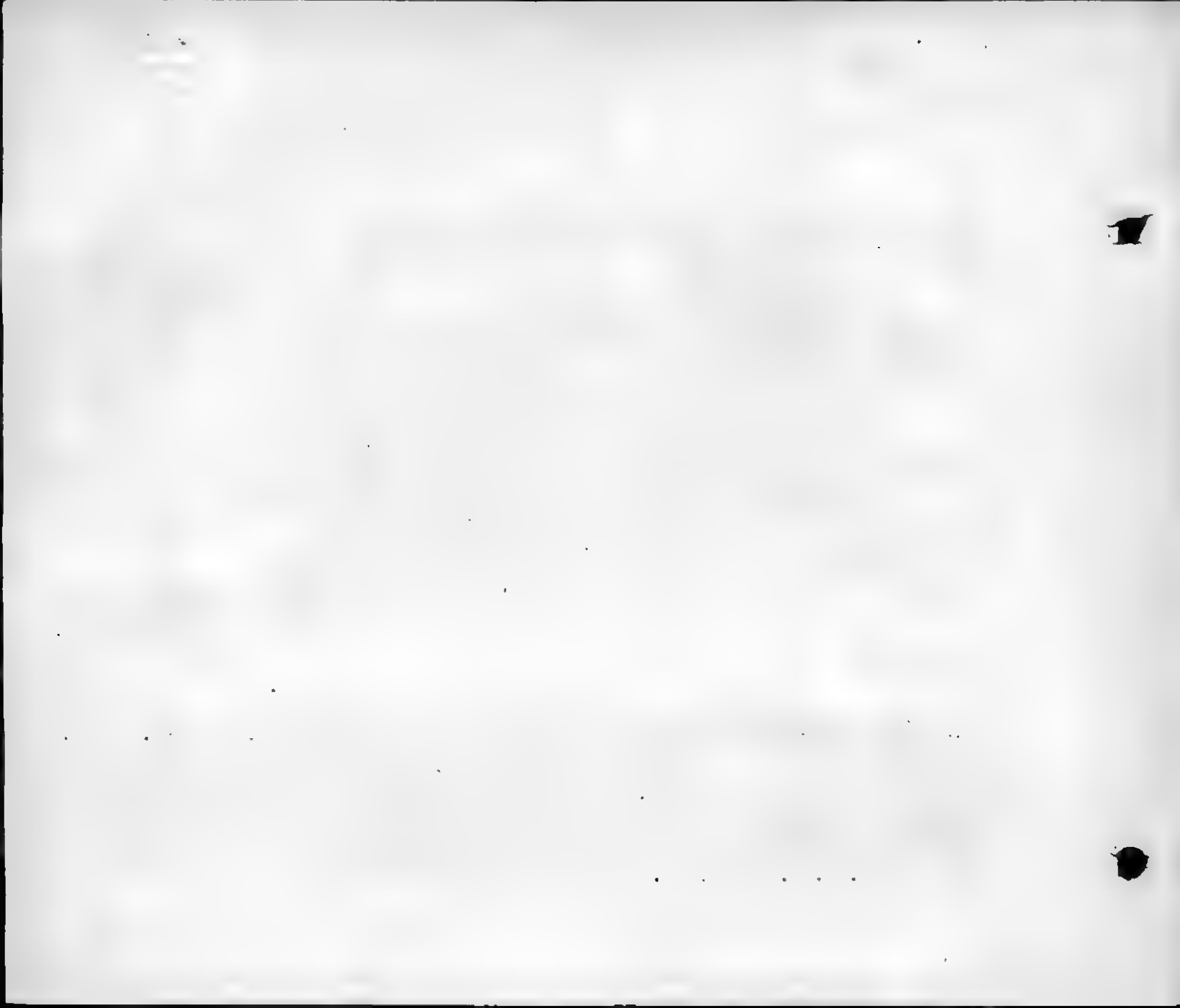
5120

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SHARPSBURG</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVER CREEK - RURAL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ALONG ROUTE 34</u>		d. STREET ADDRESS <u>HAGERSTOWN MD. R.1</u>	
3. NAME OF DECEASED (Type or print) <u>RAYMOND C. CLEVELAND SMITH</u>		4. DATE OF DEATH <u>APRIL - 17 - 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 21 - 1933</u>
9. AGE (In years last birthday) <u>27</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER SOUTHERN PACKING COMPANY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAGERSTOWN WASH. CO MD</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>RAYMOND C. SMITH SR</u>		14. MOTHER'S MAIDEN NAME <u>ALICE WEAVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO <u>220 28 - 8115</u>	
17. INFORMANT <u>MRS. SHIRLEY SMITH</u>		Address <u>HAGERSTOWN MD. R.1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO <u>Fracture Cervical Vertebrae</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Fracture Ribs, Left &amp; Right</u> DUE TO (c) <u>Compound Fracture Rt. Humerus &amp; Radius</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Instant</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Speeding car left road crashing into tree.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:41</u> a.m. <u>4-17-</u> 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State R # 34</u>		20f. (City or town) <u>Sharpsburg, Wash. Md.</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 22, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>KAGE HILL CEMETERY</u>		22d. LOCATION (City, town, or county) <u>HAGERSTOWN MD.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bair</u>		ADDRESS <u>BROOKSBORO MD.</u>	
24a. REC'D BY REGISTRAR <u>APR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

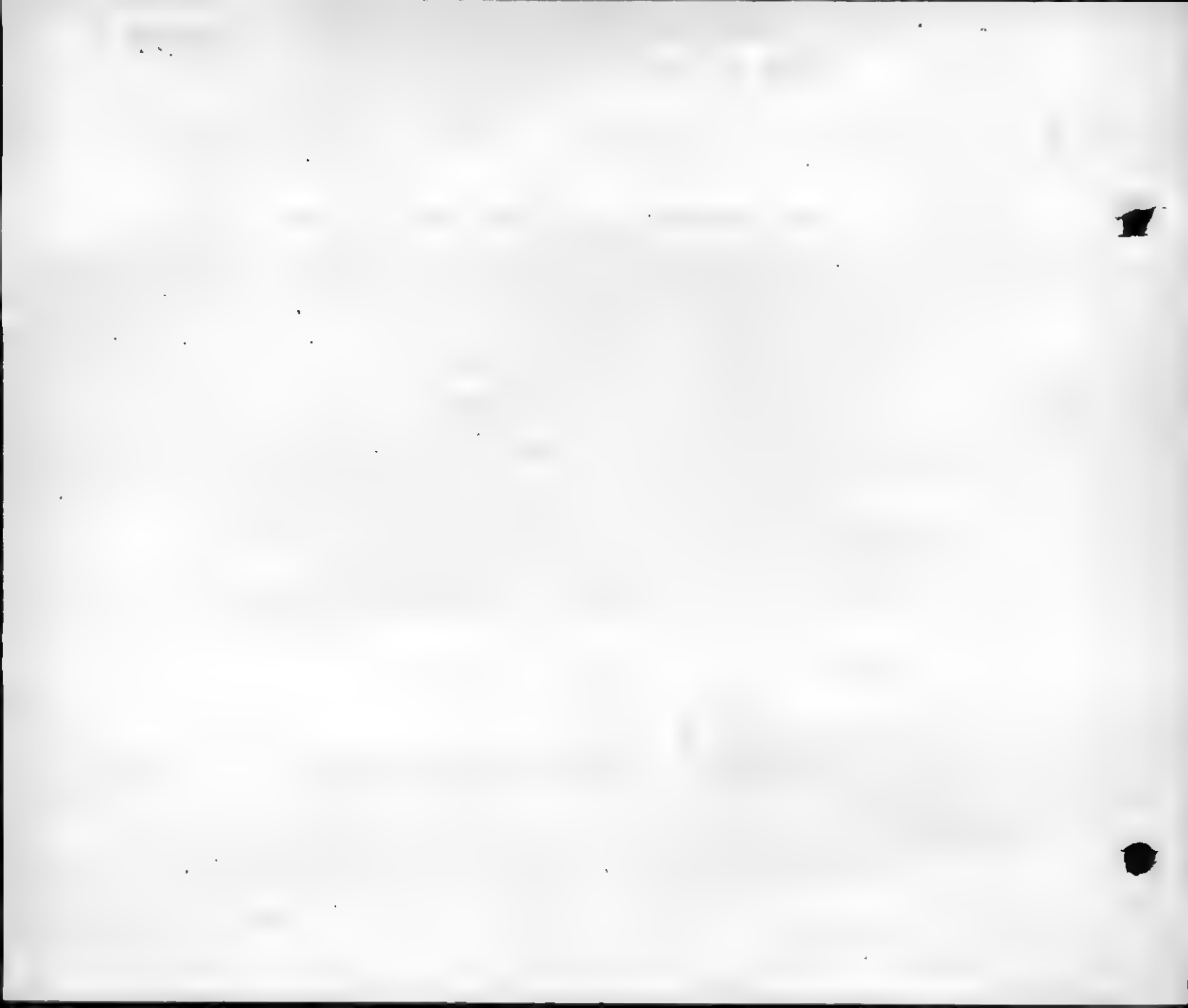
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5048

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15095

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>3 WEEKS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. Co. Hosp. &amp; Cal.</u>				e. STREET ADDRESS <u>168 S. MAIN ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN FRANKLIN SNYDER</u>				4. DATE OF DEATH Month Day Year <u>APRIL - 15 1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 2 - 1875</u>	
9. AGE (n years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RAILWAY MAIL CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WILLIAMSPORT MD</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>SIMON P. SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>MARY VIRGINIA LEEFYRE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>GEORGE W. SNYDER SMITHSBURG MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>4-2-60</u> to <u>4-15-60</u> 19 <u>60</u> , that (I) (we) lost the deceased alive on <u>4-15-60</u> 19 <u>60</u> , and that death occurred at <u>4:50 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles S. Hers</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-15-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles S. Hers</u>				22d. ADDRESS <u>Smithsburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>APRIL 18 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SMITHSBURG CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SMITHSBURG MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John D. East</u>				ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 22 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles S. Hers</u>	





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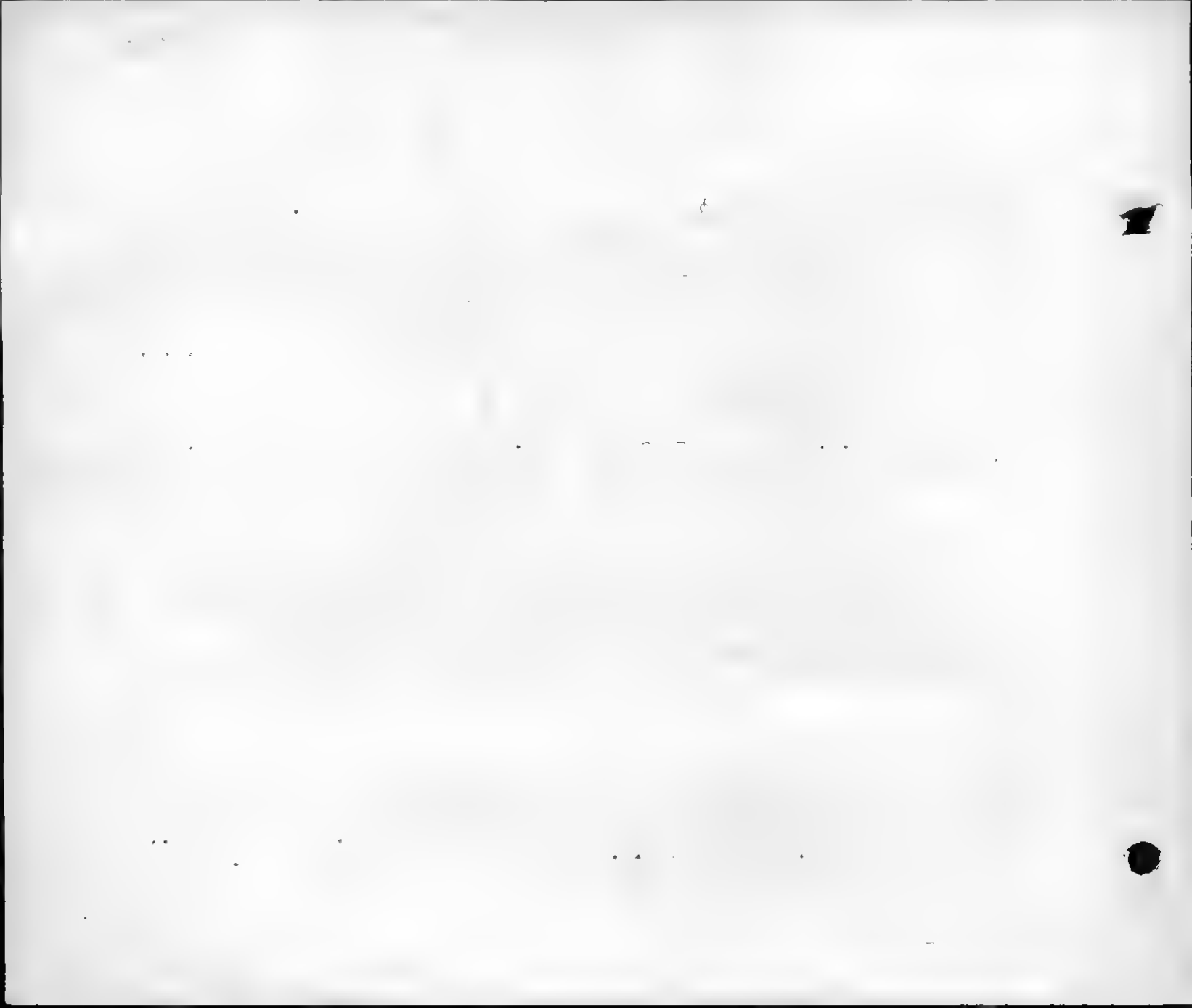
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65096

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hoopital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>EDGAR</b> Last <b>SNYDER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 21, 1891</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Boonsboro, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Martin Snyder</b>				14. MOTHER'S MAIDEN NAME <b>Ella Hildebrand</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>W.W.I</b>		16. SOCIAL SECURITY NO. <b>212-38-0001</b>		17. INFORMANT <b>Mrs. Vera Snyder</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Uncertain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4-4, 1960</b> to <b>4-16, 1960</b> that (I) (we) last saw the deceased alive on <b>4-16, 1960</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>John H. Hornbaker</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>				22d. ADDRESS <b>154 W. Washington St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/19/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Boonsboro Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Boonsboro Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>R. Franklin Rizer</b>				25a. REC'D BY REGISTRAR <b>Hagerstown, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Robert A. Rizer</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

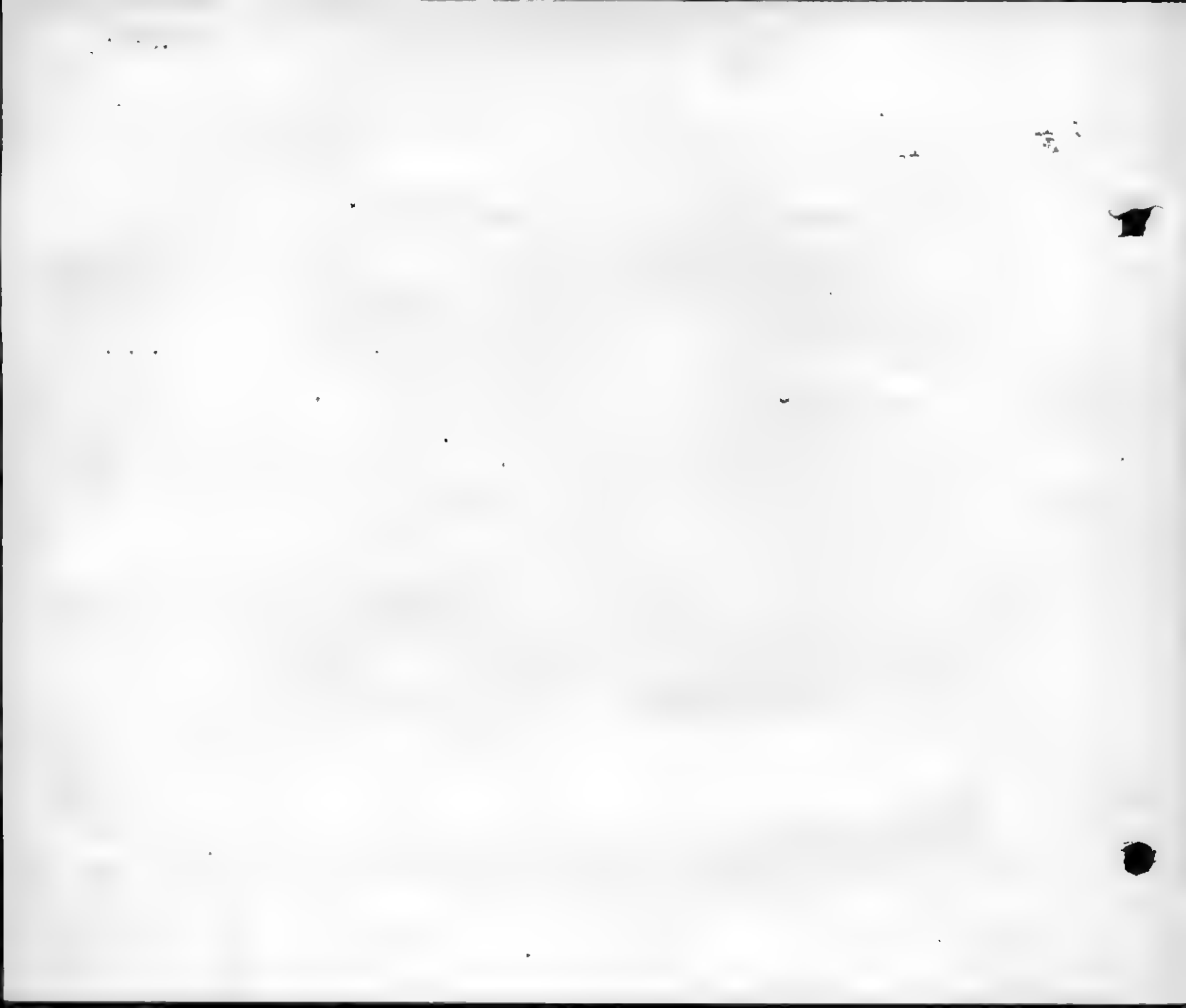


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be sent to the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
5050  
CERTIFICATE OF DEATH

65097

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>155 Madison Ave.,</u>			
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>CECIL</u> Last <u>SOCKS</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 1913</u>	
9. AGE (In years last birthday) <u>46</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Odd Jobs</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Albert Socks</u>				14. MOTHER'S MAIDEN NAME <u>Rozelia E. Shanks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		17. INFORMANT <u>George P. Socks</u> Address <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/18/60</u> to <u>4/19/60</u> , that (I) (we) last saw the deceased alive on <u>4/19/60</u> , and that death occurred <u>at 3:07 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Young</u>				22b. PHYSICIAN'S NAME (Type) <u>Joseph Young</u>		22c. DATE <u>4/20/60</u>	
22d. ADDRESS <u>Willi Augustus Md.</u>				22e. DATE <u>4/20/60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/21/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Boyer</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 25 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>							



5051

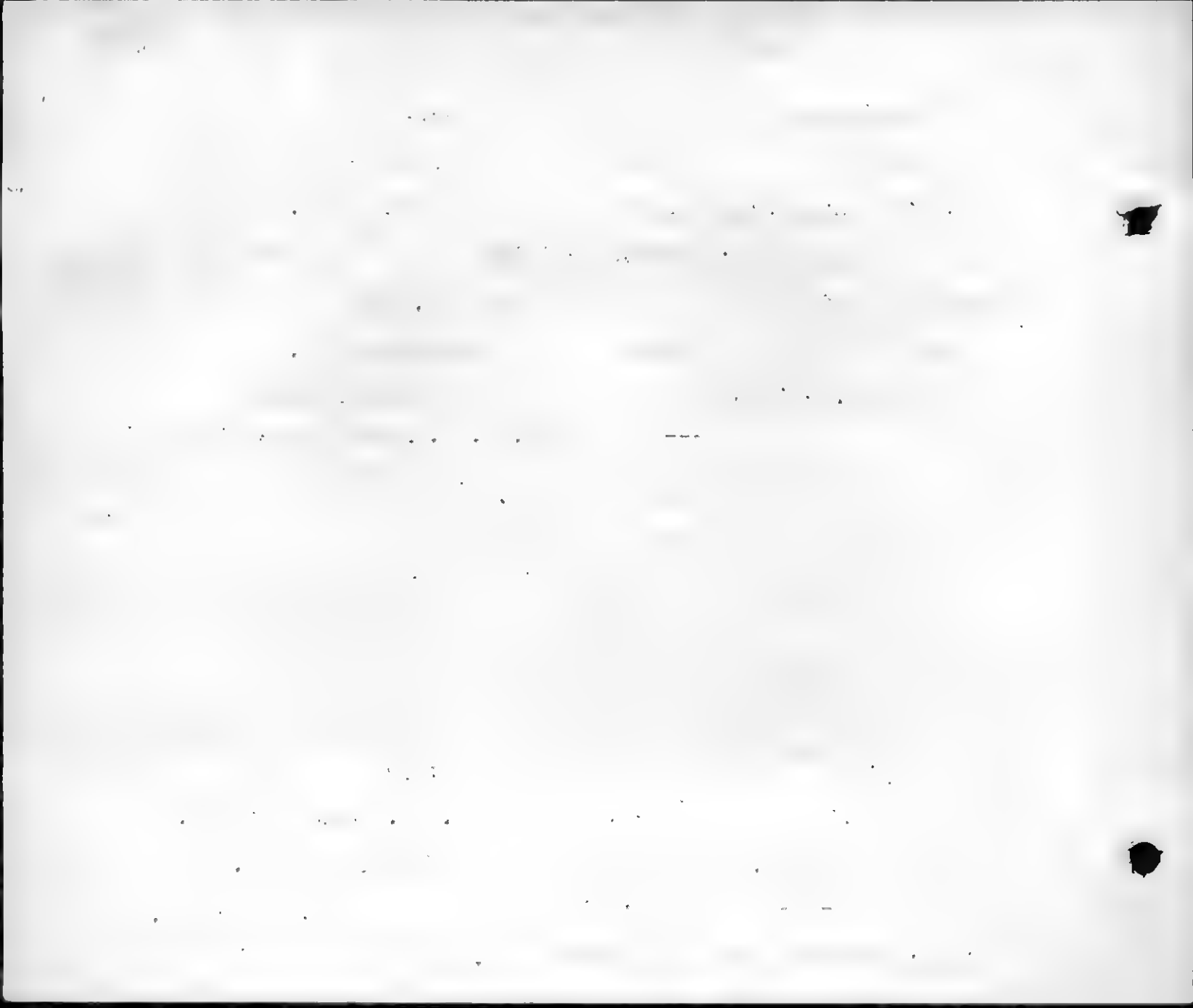
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Jackson Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Elizabeth Spielman</b>		4. DATE OF DEATH <b>April 23 1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1882</b>
9. AGE (in years last birthday) <b>78</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Samuel C. Spielman</b>	
14. MOTHER'S MAIDEN NAME <b>Ida Miller</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Mrs. J. E. Roush</b> Address <b>Cleveland Ohio</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>General arteriosclerosis</b> DUE TO <b>General arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6-8 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1, 1960</b> to <b>Apr 22, 1960</b> , that I last saw the deceased alive on <b>Apr 21, 1960</b> , and that death occurred at <b>8:05 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> M.D.		ADDRESS (Street, city or town, state) <b>217 W. Washington St.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III</b>		<b>Hagerstown Md.</b>	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-25-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b> ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>APR 26 1960</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

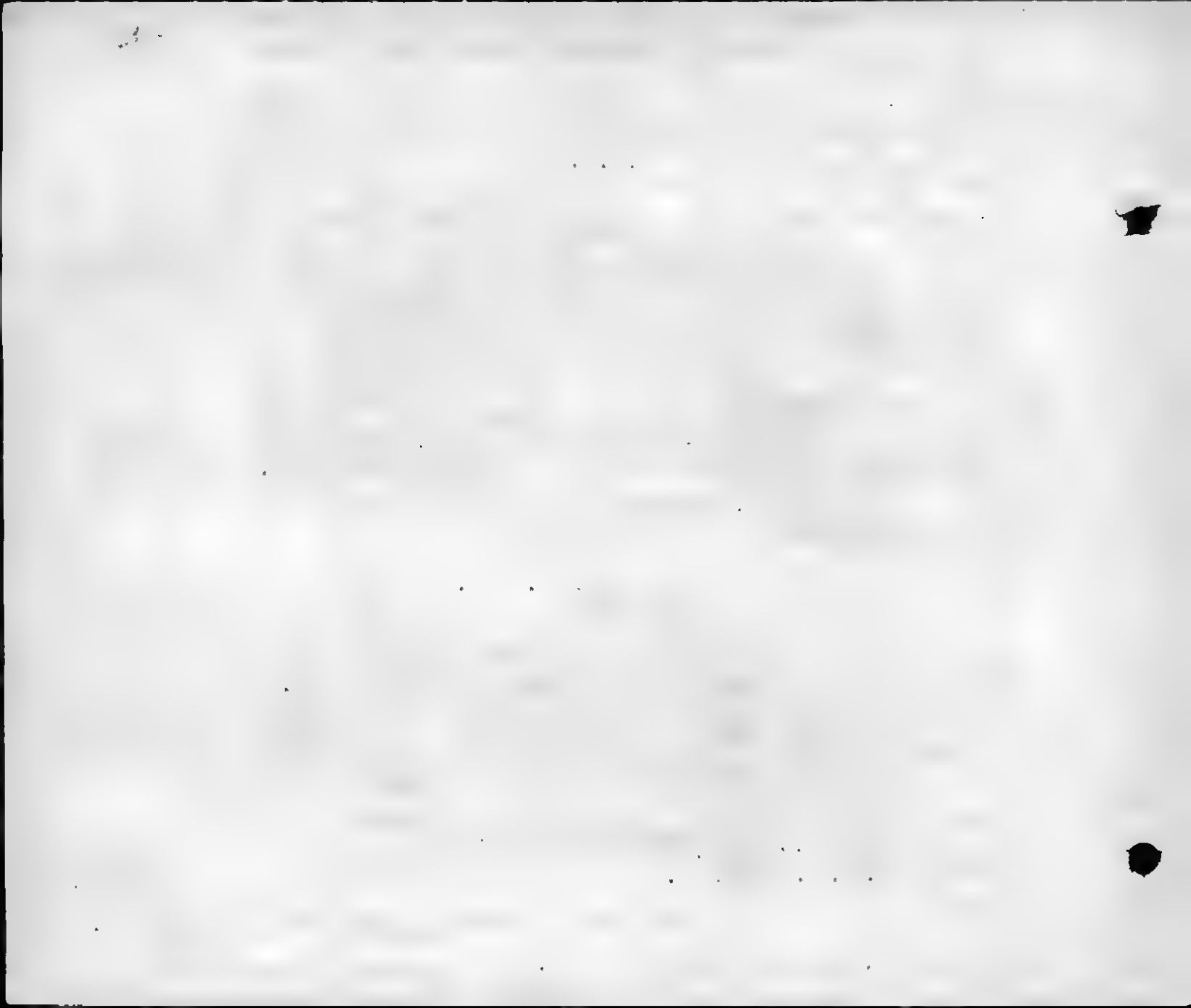
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1,5099  
Reg. Dist. No. 808

5052

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> D. O. A.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				d. STREET ADDRESS <b>631 George St</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALTON LEE STEWART Sr</b>				4. DATE OF DEATH Month Day Year <b>April 17 1960 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 19 1928</b>	
9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electronics</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Air Craft</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Stewart</b>				14. MOTHER'S MAIDEN NAME <b>Zella Shenkleton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Korean 312-24-6832</b>		17. INFORMANT Address <b>Mrs Anna B. Stewart 631 George St Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Skull</b> <b>823X</b> DUE TO <b>Crushed Chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture Lumbar Spine</b> DUE TO (c) <b>Fracture Femur, rt. &amp; lt.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Speeding car left road crashing into tree.</b>					
20c. TIME OF INJURY Month, Day, Year <b>4-17-60</b> Hour <b>7:41</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>State D-1-374</b>		20f. (City or town) (County) (State) <b>Sharpsburg Wash. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/20/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>4/20/60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>							

TO DE: MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose a certificate, writing the word "pending" in pencil in Item 18. C. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





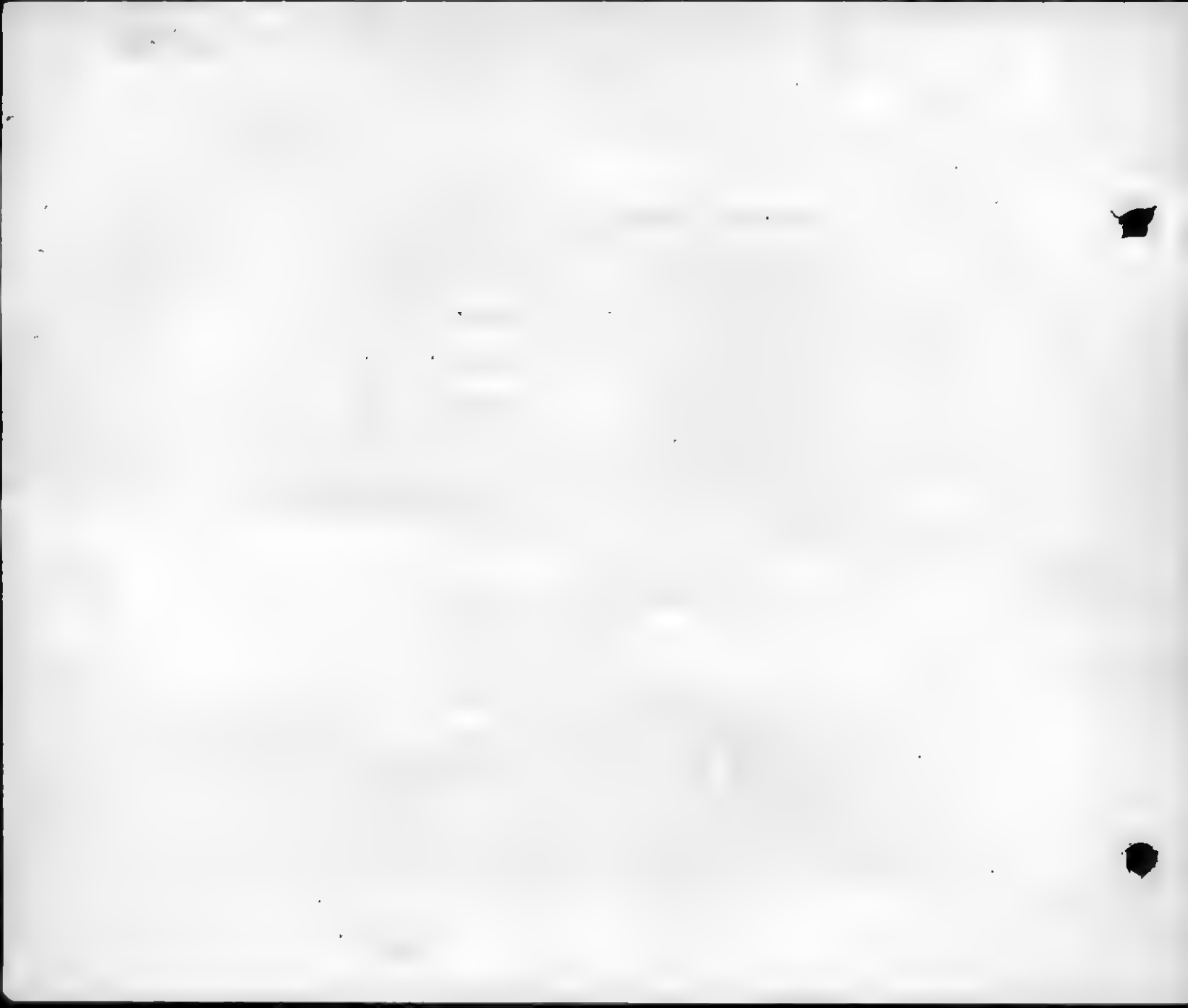
may be filled by the attending physician and completely filled by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. YOUNG  
WILLIAM SPART

7/13

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<div style="display: flex; justify-content: space-between;"> <div> <p>5053</p> <p>Item 7</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>65100</p> </div> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>X TILGHMANTON</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARTIN MANOR REST HOME</u>				e. STREET ADDRESS <u>RURAL</u>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>BESSIE</u> Middle <u>N.</u> Last <u>SUMAN</u>				<b>4. DATE OF DEATH</b> Month <u>APRIL</u> - Day <u>6</u> - Year <u>1960</u>					
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Partial</u> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JULY-21-1876</u>		<b>9. AGE</b> (In years last birthday) <u>83</u> yrs	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>TILGHMANTON WASH. CO. MD. U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		IF UNDER 1 YEAR: Months <u>8</u> Days <u>15</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.: Hours <u></u> Min. <u></u>	
<b>13. FATHER'S NAME</b> <u>JOSIAH BLOOM</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ELEANOR FITCH</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> Address <u>MISS M. IRENE BLOOM TILGHMANTON MD.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rec. Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ray</u> DUE TO (c) <u></u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>4/5/60</u> <b>19</b> to <u>4/6/60</u> <b>19</b> , that (I) (we) lost saw the deceased alive on <u>4/6/60</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above									
<b>22a. SIGNATURE</b> <u>Robert F. Young</u>				<b>22b. PHYSICIAN'S NAME</b> (Type) <u>Robert F. Young M.D.</u>		<b>22c. ADDRESS</b> <u>William Spert, Md.</u>		<b>22d. DATE SIGNED</b> <u>4/7/60</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>APRIL-9-1960</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MAJOR CEMETERY</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>NEAR TILGHMANTON MD</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John H. Baer</u>				<b>24b. ADDRESS</b> <u>Boonsboro MD.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>APR 12 '60</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>W. L. S. Kneib</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

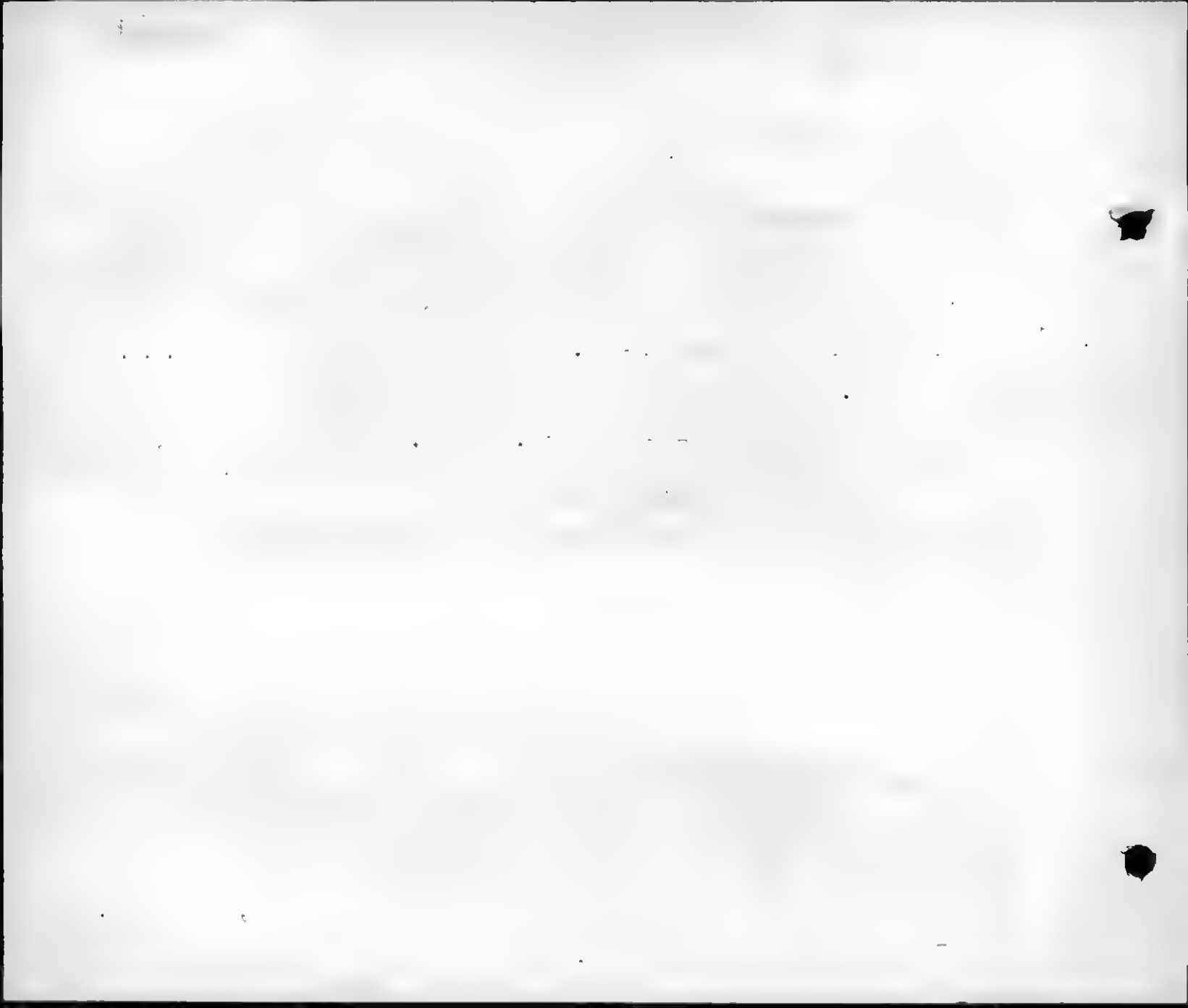
VR A15 (4)  
ISM 9/59

5054

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

05101

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELSIE</b> Middle <b>MINNIE</b> Last <b>SWINK</b>				4. DATE OF DEATH Month <b>April</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 4, 1901</b>	
9. AGE (In years lost birthday) <b>59</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chief Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Carl N. Boger</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Fink</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-10-0096</b>		17. INFORMANT <b>Mrs. Peter H. Priest</b>		Address <b>Hagerstown, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>44-3-X</b> IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Hagerstown</b>				20g. (County) <b>Maryland</b>		20h. (State) <b>Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Mon 31</b> 19 <b>60</b> , to <b>Apr 1</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>Apr 1</b> 19 <b>60</b> , and that death occurred at <b>5:15</b> M. from the causes and on the date stated above.							
22a. SIGNATURE <b>John C. Stauffer</b>				22b. DATE SIGNED <b>APR 5 '60</b>		22c. PHYSICIAN'S NAME (Type) <b>John C. Stauffer</b>	
22d. ADDRESS <b>Hagerstown, Maryland</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/4/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Boger</b>				25a. REC'D BY REGISTRAR <b>APR 5 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

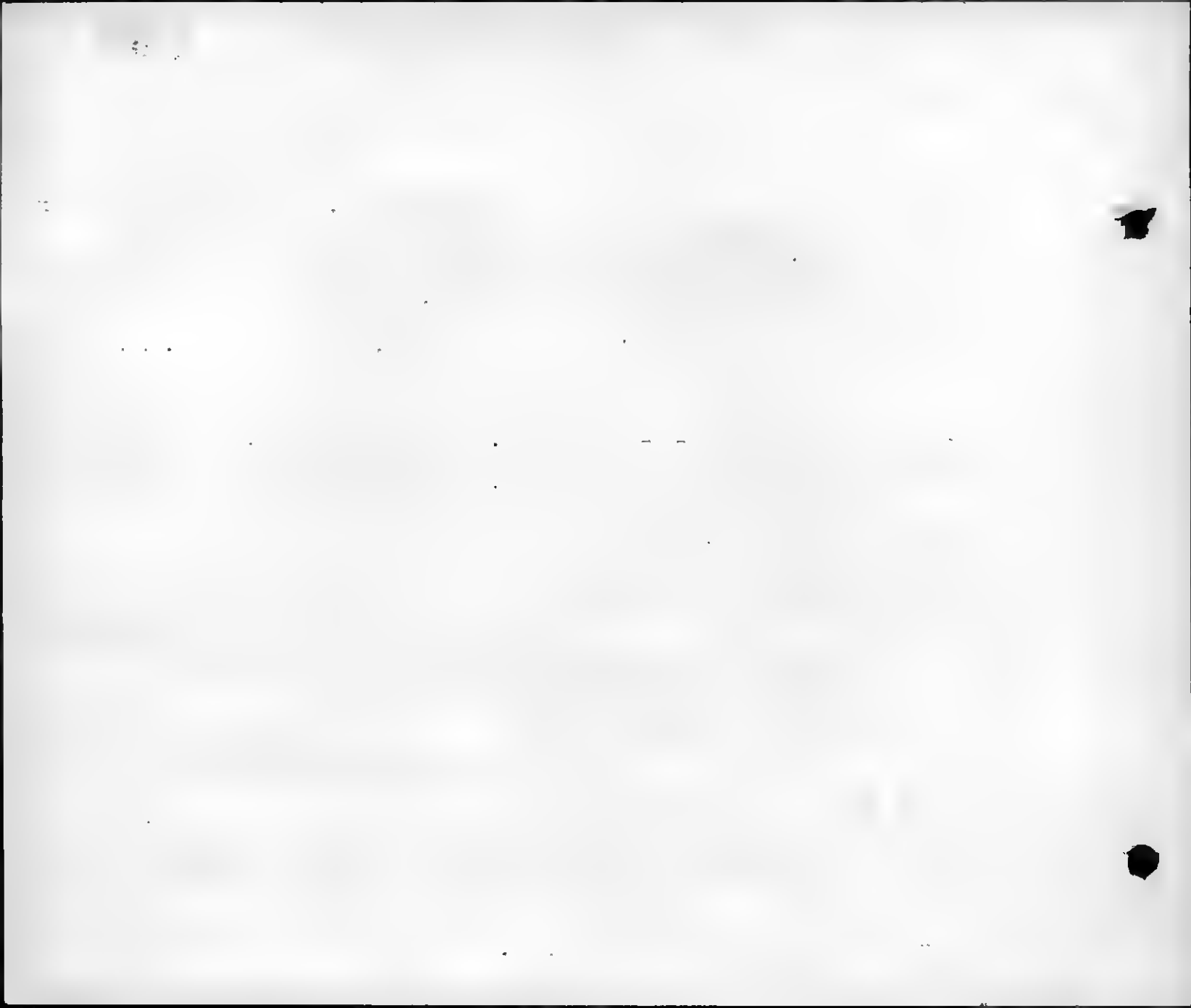
VR AIS (4)  
ISM 9/59

5055

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

65102

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b>			
f. STREET ADDRESS <b>1020 Georgia Ave.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MADELINE ELIZABETH SWISHER</b>				4. DATE OF DEATH <b>April 7 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 14, 1915</b>	
9. AGE (In years last birthday) <b>44</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesclerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Newberry's</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Albert Magaha</b>				14. MOTHER'S MAIDEN NAME <b>Grace Hankey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>214-09-8455</b>		17. INFORMANT <b>John A. Swisher Hagerstown, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix - extensive regional</b> <b>171X</b> DUE TO <b>metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>May 1959</b> to <b>7 Apr 1960</b> , that (I) (we) last saw the deceased alive on <b>7 Apr 1960</b> , and that death occurred at <b>313A</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>F. F. Lusk</b>				22b. DATE SIGNED <b>8 Apr 60</b>			
22c. PHYSICIAN'S NAME (Type) <b>F. F. Lusk</b>				22d. ADDRESS <b>2301 N. Potomac Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/9/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Suter - Rouzer Funeral Home</b> <b>B. Franklin Rouzer</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>APR 11 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kram</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

5056

65103

1. PLACE OF DEATH a. COUNTY <b>Kx Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Doubs</b> 10X 2.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Western Maryland State Hospital</b>				d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emma Gertrude Talbott</b>				4. DATE OF DEATH Month Day Year <b>4 29 1960</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8 June 1869</b>		9 AGE (In years lost birthday) yrs <b>90</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-work</b>		10b KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jonathan Talbott</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Frances Walters</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>309 N. Frederick Ave., Roy L. Talbott, Gaithersburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Pancreas</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 months</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular disease, Cerebral thrombosis</b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <b>Oct. 9 1958</b> to <b>April 29 1960</b> that (I) (we) last saw the deceased alive on <b>April 29 1960</b> and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above							
22a SIGNATURE <b>Young E. Chun</b>				22b DATE SIGNED <b>April 29 1960</b>		22c PHYSICIAN'S NAME (Type) <b>Young E. Chun</b>	
22d ADDRESS <b>1500 Penna. Ave. Hagerstown, Md.</b>							
23a BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>5-3-60</b>		23c NAME OF CEMETERY OR CREMATORY <b>Monocacy Cemetery</b>		23d LOCATION (City, town, or county) (State) <b>Beallsville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a REC'D BY REGISTRAR DATE <b>MAY 2 '60</b>		25b. REGISTRAR'S SIGNATURE <i>William L. Hume</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
15M 9/59

1

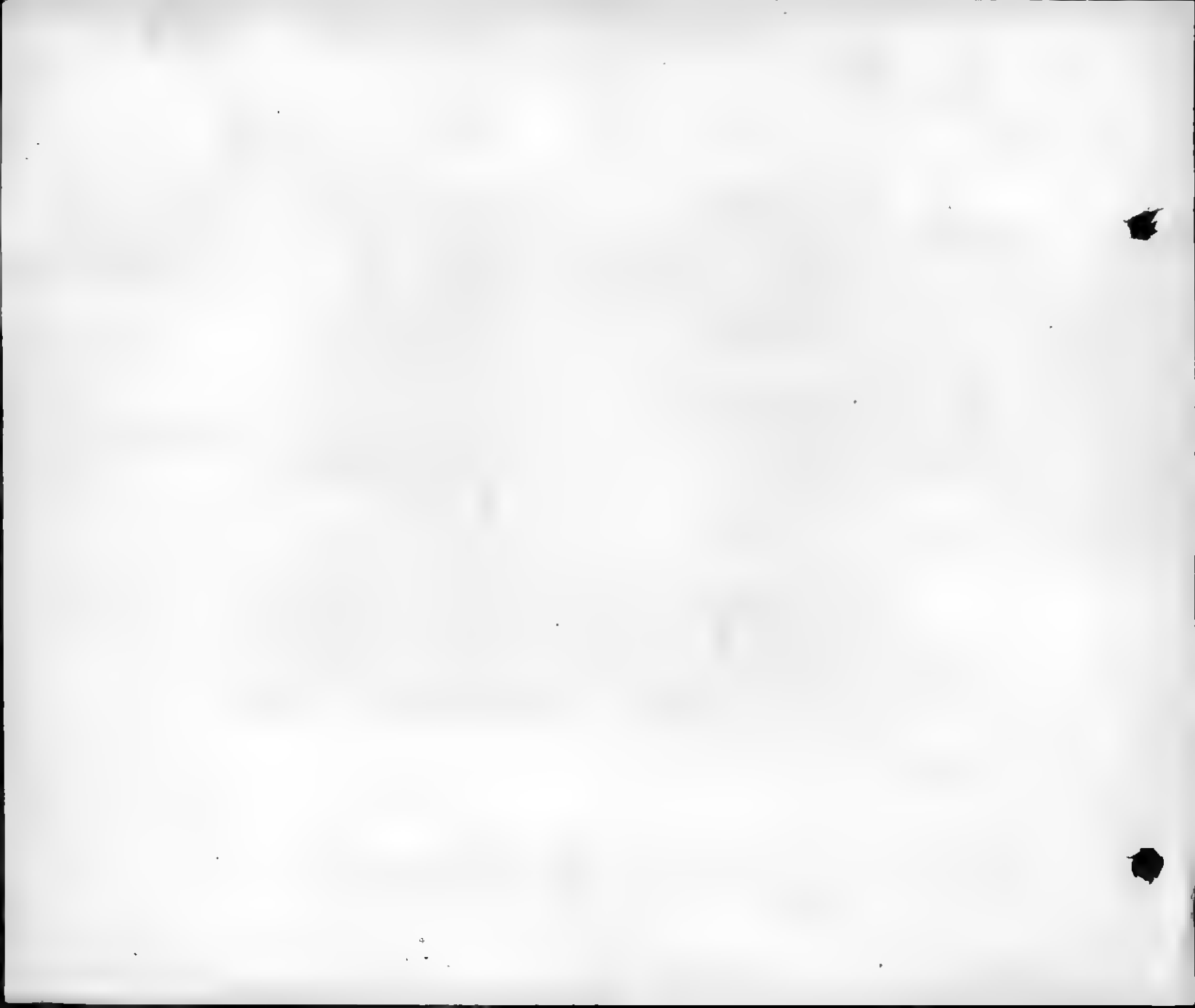
5057

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05104  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>3 Weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM AUGUSTUS TOBIAS Jr</b>				4. DATE OF DEATH Month Day Year <b>April 16 1960 19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 28 1878</b>	
9. AGE (in years last birthday) <b>81</b> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Senior Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Draft Board</b>			
11. BIRTHPLACE (State or foreign country) <b>Reading Berks Co Pa</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>William A. Tobias Sr</b>				14. MOTHER'S MAIDEN NAME <b>Amanda</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>314-09-1459</b>		17. INFORMANT Address <b>Mrs Daisy Tobias 927 Hamilton Blvd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Esophagus</b> DUE TO <b>181.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>181.0</b> DUE TO (c) <b>181.0</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 16 1960</b> to <b>4/16/60</b> , that (I) (we) last saw the deceased alive on <b>4/16/60</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Andrew K. Coffman</b> M.D.				22b. DATE SIGNED <b>April 15/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Andrew K. Coffman</b>				22d. ADDRESS <b>11-2-1051</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/18/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman, Hagerstown, Md</b>				25a. REC'D BY REGISTRAR <b>APR 20 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5058 CERTIFICATE OF DEATH

65105  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>7 1/2 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>Paulding</b> Last <b>Towson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>11</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR: Months <b>8</b> Days <b>11</b> Hours <b>11</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Huntington, L.I., N.Y.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Hiram Paulding</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Mulligan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-34-4195</b>	
INFORMANT <b>A. Lee Towson, Jr., Lewiston, N.Y.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>7 1/2 hrs.</b> <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-60</b> , 19 <b>60</b> , to <b>4-11-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>4-11-60</b> , 19 <b>60</b> , and that death occurred at <b>1:00 P.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles E. Hess</b>		M.D. <b>Smithsburg, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>4-13-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 14 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

420.1

5059

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b -	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Vannie</b> First <b>Veon</b> (John) Middle <b>Virts</b> Last		4. DATE OF DEATH <b>4</b> Month <b>9</b> Day <b>19</b> Year <b>60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-12-1906</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furloughed Faiechild</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John R. Virts</b>		14. MOTHER'S MAIDEN NAME <b>SCHILLING</b> <b>Ida E. Schilling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Informant</b> <b>Mrs. Ethel Virts, Boonesboro, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Essential hypertension</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>5 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 9, 1960</b> to <b>April 9, 1960</b> , that I last saw the deceased alive on <b>April 2, 1960</b> , and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>- J. Secondari</b>		ADDRESS (Street, city or town, state) <b>21 North Main St.</b> DATE SIGNED <b>4/11/60</b>	
PHYSICIAN'S NAME (Type) <b>Joseph Secondari, M.D.</b>		<b>Boonesboro, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-12-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Park Heights</b>	22d. LOCATION (City, town, or county) (State) <b>Brunswick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. H. Fute</b>		24a. REC'D BY REGISTRAR <b>DATE MAY 5 '60</b>	
ADDRESS <b>Brunswick, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

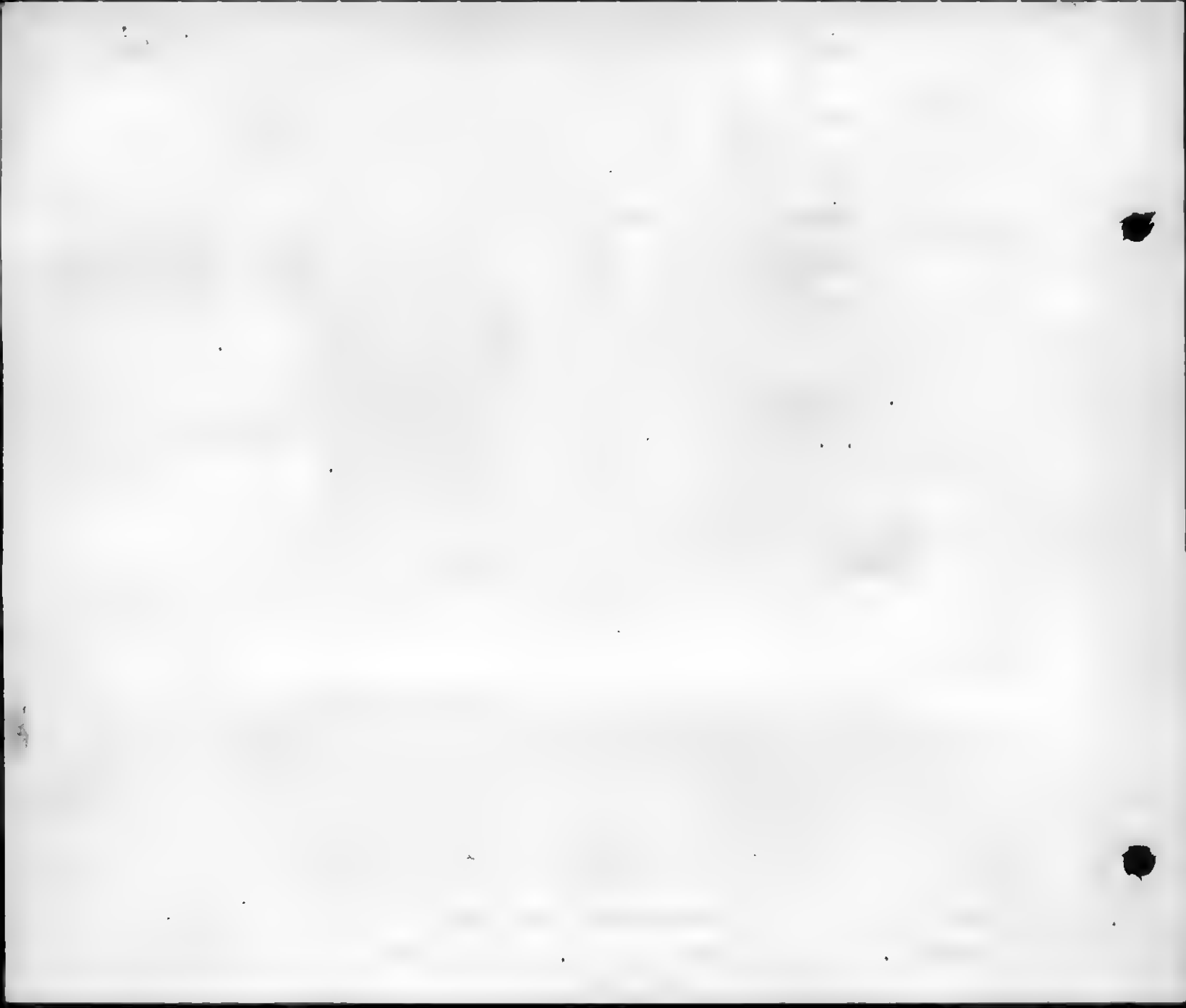
VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

5060

302 05107

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>5 Mos</b>				d. STREET ADDRESS <b>926 Oak Hill Ave</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>926 Oak Hill Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SCOTT</b> Middle <b>RAYMOND</b> Last <b>WAGNER</b>				4. DATE OF DEATH Month <b>April</b> Day <b>5</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 16 1874</b>	
9. AGE (In years lost birthday) yrs <b>85</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clergyman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Ickesburg Perry Co Pa.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John W. Wagner</b>			
14. MOTHER'S MAIDEN NAME <b>Sarah Eliz Eby</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>W.W.# 1</b>			
16. SOCIAL SECURITY NO. <b>217-32-6046</b>				17. INFORMANT <b>Mrs Lorene Fox Wagner</b> Address <b>926 Oak Hill Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vasc. Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 yrs</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aneurysm of Abdominal Aorta - 5 mo.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 1</b> 19 <b>60</b> , to <b>Apr 5</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>4-5</b> 19 <b>60</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert P. Conrad, MD</b>				22b. DATE SIGNED <b>4-5-60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert P. Conrad</b>				22d. ADDRESS <b>137 W. Washington Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hummelstown Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hummelstown Dauphin Co Pa</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				25a. REC'D BY REGISTRAR <b>APR 11 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	





5061

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

65108

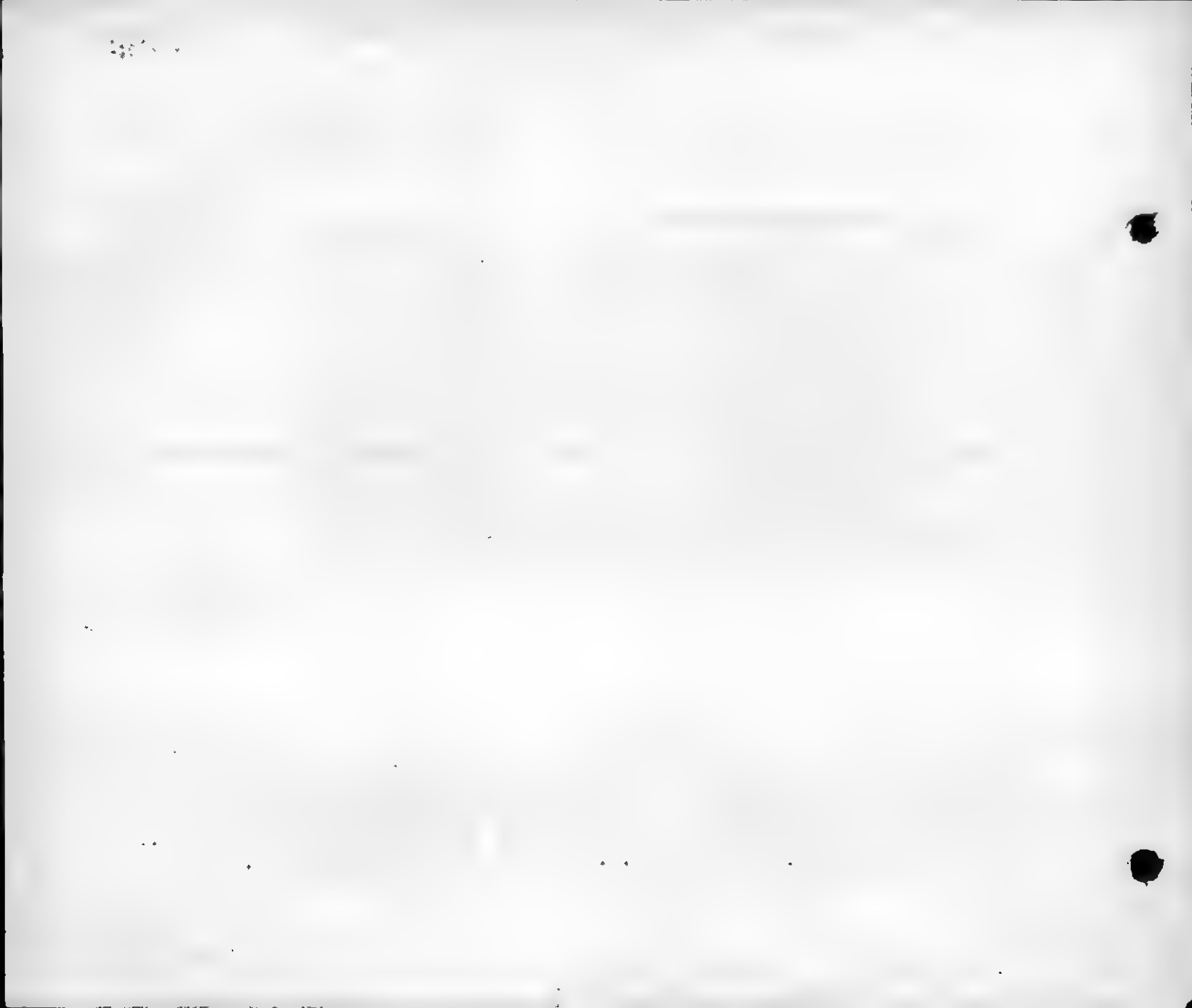
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruby</u> Middle <u>Hazel</u> Last <u>Walls</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 11, 1916</u>	
9. AGE (In years last birthday) <u>43</u> yrs		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>1</u> Min.		IF UNDER 24 HRS Months <u>4</u> Days <u>4</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Machine Operator Sewing Factory</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Jacob Bros.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Millard F. Bishop</u>				14. MOTHER'S MAIDEN NAME <u>Anna B. Munson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Ramona Creek Hancock, Md.</u>			
17. INFORMANT <u>Ramona Creek Hancock, Md.</u>				Address			
1B CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Anterioschrotic (coronary) Heart Disease</u> <u>42</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Multiple pulmonary emboli</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>about 2 years - 1 month?</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-29, 1960</u> to <u>4-4, 1960</u> , that (I) (we) last saw the deceased alive on <u>4-4, 1960</u> , and that death occurred at <u>7:50 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Hornbaker</u> M.D.				22b. DATE SIGNED <u>APR 12 '60</u>			
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>				22d. ADDRESS <u>154 West Washington St., Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>4-8-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>				25a. REC'D BY REGISTRAR <u>Howard J. Stone</u>			
ADDRESS <u>Hancock Md</u>				25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>			

081

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5121

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

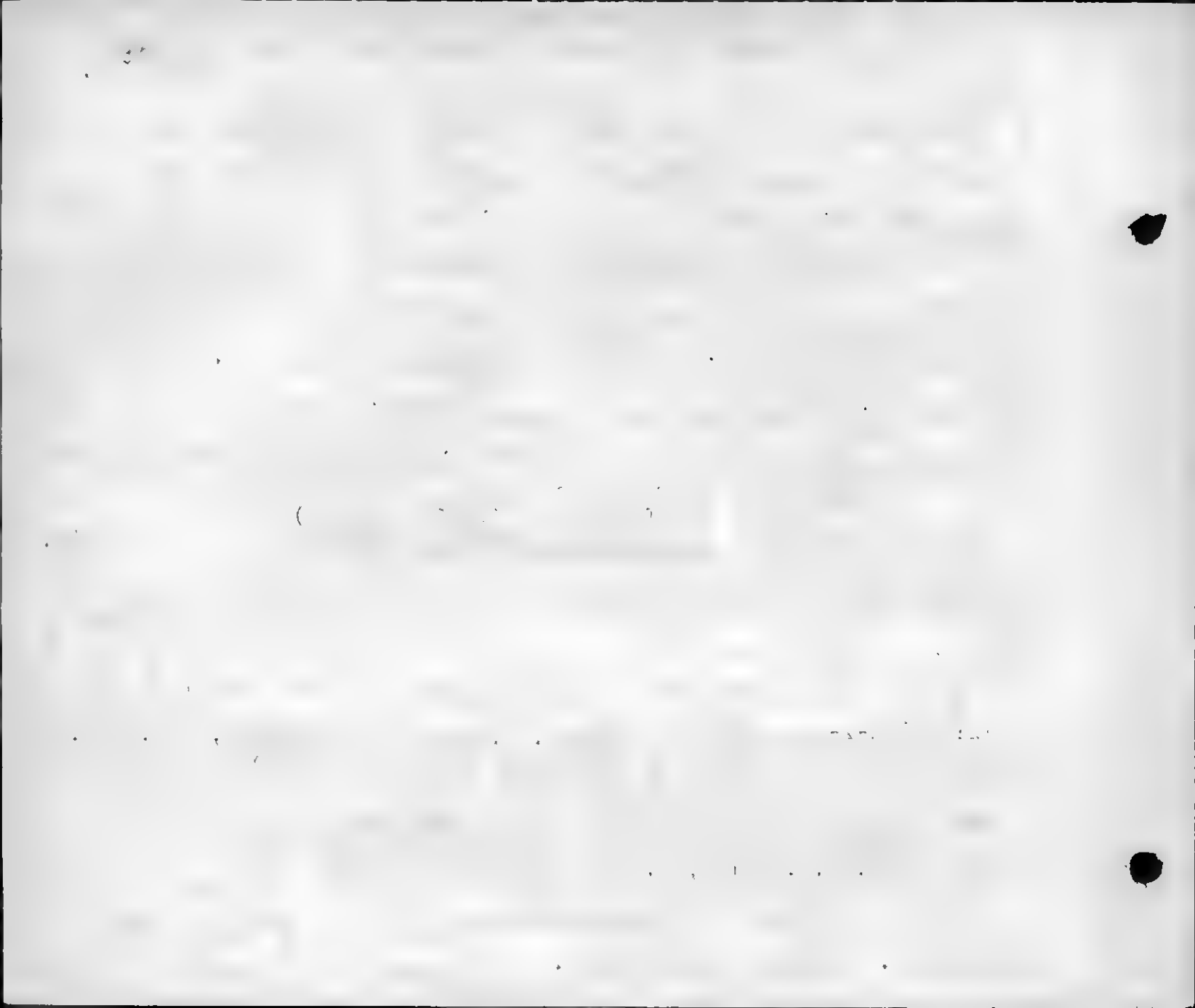
Reg. Off. No. 05109

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ringgold</b>				c. LENGTH OF STAY IN 1b <b>10 Min</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Junction</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			
f. STREET ADDRESS <b>W. Md College</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARGARET CHRISTINE WAPPLER</b>				4. DATE OF DEATH Month Day Year <b>April 3 1960 19</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>May 17 1932</b>		9. AGE (In years last birthday) <b>27</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. Md College</b>		11. BIRTHPLACE (State or foreign country) <b>Denver Denver Co Colo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Werner J. Wappler</b>				14. MOTHER'S MAIDEN NAME <b>Ruth F. Francis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>----</b>		17. INFORMANT Address <b>Werner J. Wappler 5685 Minnesota Ave Denver 22 Colo</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>16X</b> <b>FRACTURED SKULL</b> DUE TO <b>ERACTURED RIBS (CHEST CRUSHED)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>COUMPOUND FRACTURE LOWER JAW</b> DUE TO <b>FRACTURE OF LEFT WRIST</b> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>RAMED THRU STOP SIGN-STRUCK BY TRACTOR TRAILER</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>12:45 p.m. 4-2- '60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>JUNC. RT. 64&amp;418</b>		20f. (City or town) (County) (State) <b>LEITERSBURG, WASH. MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>[Signature]</b> M.D. <b>DR. E.W. DITTO, JR.</b>				DATE SIGNED <b>4/3/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fair Mount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Denver Denver Co Colo</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>APR 5 '60</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and inform the funeral director within 72 hours after death.

VR A15 (4)  
15M 9/59

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5062  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
302 05110

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>23Yrs</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1127 Oak Hill Ave</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>1127 Oak Hill Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>STANLEY TELFORD WELDER</b>		4. DATE OF DEATH Month Day Year <b>April 21 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 13, 1897</b>
9. AGE (In years last b rthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>62 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Sales Mang Hoffman Chevrolet Reading Berks Co Pa</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William F. Welder</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hazelhurst</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes W.W#1</b>		16. SOCIAL SECURITY NO <b>314-09-3998</b>	
17. INFORMANT <b>Mrs Ruth C. Welder, 1127 Oak Hill Ave</b>		Address <b>Hagerstown Maryland</b>	
18. CAUSE OF DEATH [Enter any one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>400</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Isolate, 1st time, 16 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1960</b> to <b>April 1960</b> , that (I) (we) last saw the deceased alive on <b>April 1960</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>APR 25 '60</b>	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS <b>[Signature]</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/24/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR <b>APR 25 '60</b>	
ADDRESS <b>Hagerstown, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/58

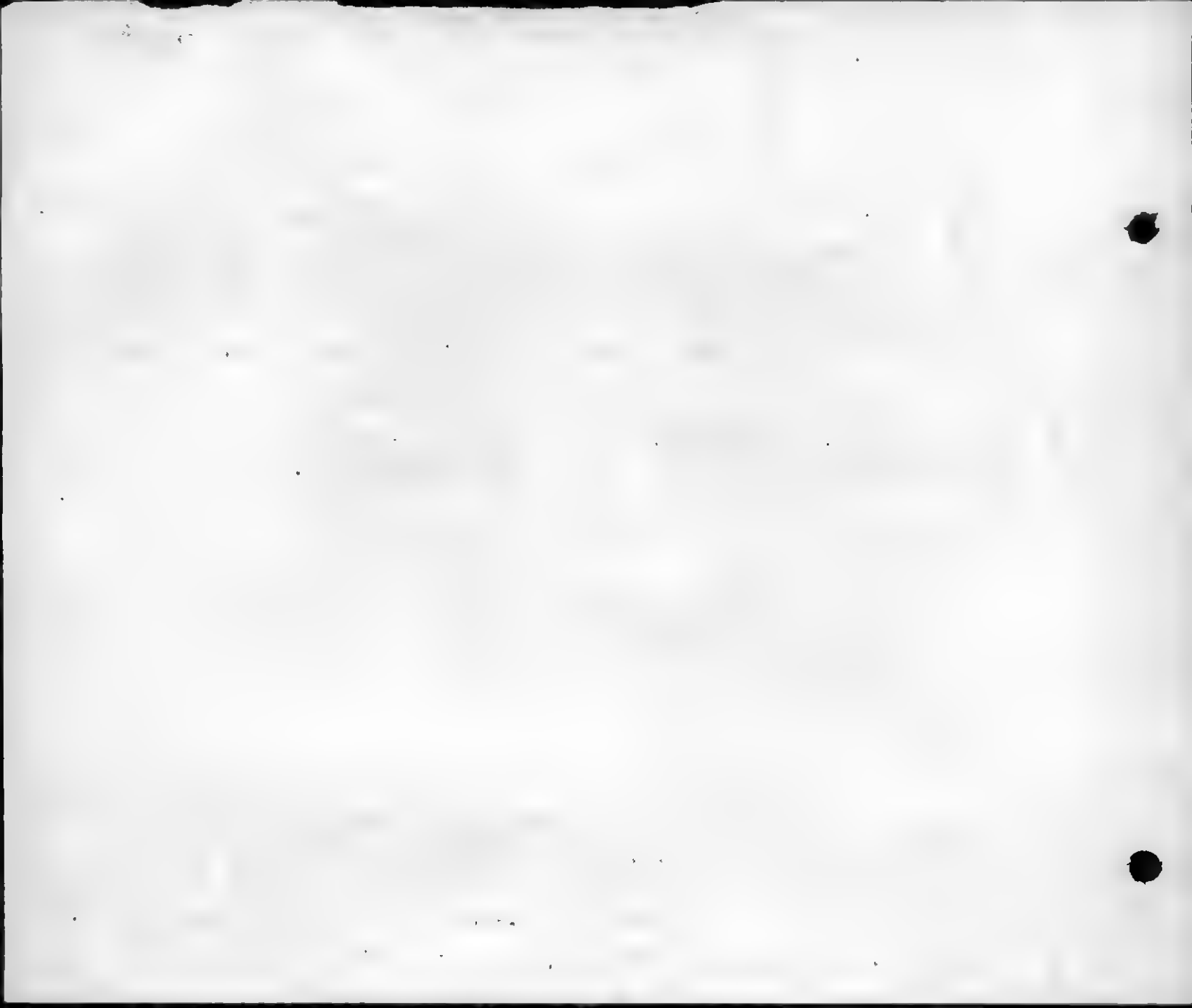
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

5003

302

65111

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>4 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>525 Frederick St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DAVID EARL WOLF Sr</b>		4. DATE OF DEATH Month Day Year <b>April 20 1960 19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25 1891</b> 9. AGE (In years lost birthday) yrs <b>68</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wolf &amp; Son</b>	
11. BIRTHPLACE (State or foreign country) <b>Boonsboro Wash Co Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Wolf</b>		14. MOTHER'S MAIDEN NAME <b>Laura Martz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>314-09-8133</b>	
17. INFORMANT <b>Mrs Lillian Wolf</b>		Address <b>525 Frederick St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.0</b> DUE TO Conditions if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 month.</b> <b>1 year.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 18, 1960</b> to <b>Apr. 20, 1960</b> that (I) (we) last saw the deceased alive on <b>Apr. 20, 1960</b> , and that death occurred <b>1:32 P</b> from the causes and on the date stated above			
22a. SIGNATURE <b>R. A. Bell</b>		22b. DATE SIGNED <b>Apr. 22, 1960.</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. A. Bell, M.D.</b>		22d. ADDRESS <b>Hagerstown, Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>4/23/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash Co MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		25a. REC'D BY REGISTRAR DATE <b>APR 25 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5066

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05112  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BARR</b> Middle <b>WARREN</b> Last <b>WOLFE</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>25</b> Year <b>19 60</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/12/1903</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GENL. CONTRACTOR</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WADE WOLFE</b>				14. MOTHER'S MAIDEN NAME <b>EVA WARRENFELTZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-09-1215</b>		17. INFORMANT <b>MR. DELPHIN WOLFE</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>Death by a cardiac Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>general arteriosclerosis &amp; arterio-sclerotic heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>5 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Edward W. Ditto III</b> , M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/26/60</b>	
EXAMINER'S NAME (Type) <b>Edward W. Ditto III, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/28/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REFORMED CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>WOLFESVILLE MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horvath, Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE APR 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

8113

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Rector	
19. Signature of Pastor		20. Signature of Priest		21. Signature of Rabbi	
22. Signature of Imam		23. Signature of Minister of Religion		24. Signature of Minister of Religion	
25. Signature of Minister of Religion		26. Signature of Minister of Religion		27. Signature of Minister of Religion	
28. Signature of Minister of Religion		29. Signature of Minister of Religion		30. Signature of Minister of Religion	
31. Signature of Minister of Religion		32. Signature of Minister of Religion		33. Signature of Minister of Religion	
34. Signature of Minister of Religion		35. Signature of Minister of Religion		36. Signature of Minister of Religion	
37. Signature of Minister of Religion		38. Signature of Minister of Religion		39. Signature of Minister of Religion	
40. Signature of Minister of Religion		41. Signature of Minister of Religion		42. Signature of Minister of Religion	
43. Signature of Minister of Religion		44. Signature of Minister of Religion		45. Signature of Minister of Religion	
46. Signature of Minister of Religion		47. Signature of Minister of Religion		48. Signature of Minister of Religion	
49. Signature of Minister of Religion		50. Signature of Minister of Religion		51. Signature of Minister of Religion	
52. Signature of Minister of Religion		53. Signature of Minister of Religion		54. Signature of Minister of Religion	
55. Signature of Minister of Religion		56. Signature of Minister of Religion		57. Signature of Minister of Religion	
58. Signature of Minister of Religion		59. Signature of Minister of Religion		60. Signature of Minister of Religion	
61. Signature of Minister of Religion		62. Signature of Minister of Religion		63. Signature of Minister of Religion	
64. Signature of Minister of Religion		65. Signature of Minister of Religion		66. Signature of Minister of Religion	
67. Signature of Minister of Religion		68. Signature of Minister of Religion		69. Signature of Minister of Religion	
70. Signature of Minister of Religion		71. Signature of Minister of Religion		72. Signature of Minister of Religion	
73. Signature of Minister of Religion		74. Signature of Minister of Religion		75. Signature of Minister of Religion	
76. Signature of Minister of Religion		77. Signature of Minister of Religion		78. Signature of Minister of Religion	
79. Signature of Minister of Religion		80. Signature of Minister of Religion		81. Signature of Minister of Religion	
82. Signature of Minister of Religion		83. Signature of Minister of Religion		84. Signature of Minister of Religion	
85. Signature of Minister of Religion		86. Signature of Minister of Religion		87. Signature of Minister of Religion	
88. Signature of Minister of Religion		89. Signature of Minister of Religion		90. Signature of Minister of Religion	
91. Signature of Minister of Religion		92. Signature of Minister of Religion		93. Signature of Minister of Religion	
94. Signature of Minister of Religion		95. Signature of Minister of Religion		96. Signature of Minister of Religion	
97. Signature of Minister of Religion		98. Signature of Minister of Religion		99. Signature of Minister of Religion	
100. Signature of Minister of Religion		101. Signature of Minister of Religion		102. Signature of Minister of Religion	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5096 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 65113

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN lb 64 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Williamsport			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 24 E. Salisbury Street				d. STREET ADDRESS 24 E. Salisbury Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Josephine Middle C. Zimmerman Last				4. DATE OF DEATH Month April Day 7 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18 1895		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 11 Days 19	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Emmett Cullen				14. MOTHER'S MAIDEN NAME Margaret Eva Cushwa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Sumner Draper T Mathews N. Carolina			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Vascular Disease (c) INTERVAL BETWEEN ONSET AND DEATH 10 years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) ALBERT LEAF				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 9-1960		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
				22d. LOCATION (City, town, or county) Hagerstown		22e. (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf				ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR DATE APR 11 '60	
				24b. REGISTRAR'S SIGNATURE Catharine B. [Signature]			

DATE SIGNED 4/7/60

